YOUTH JUSTICE FEASIBILITY STUDY

A PROPOSAL FOR AN INTEGRATED ASSESSMENT AND TREATMENT SERVICE

FOR

CONDUCT DISORDER / ANTISOCIAL YOUTH

IN NOVA SCOTIA

Submitted to: Children and Youth Action Committee of Nova Scotia and
Justice Canada (File No. 6133-5-23)

Submitted by:

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THIS REPORT WAS COMMISSIONED BY THE CHILDREN AND YOUTH ACTION COMMITTEE OF NOVA SCOTIA WITH FUNDING PROVIDED BY JUSTICE CANADA THROUGH THE YOUTH JUSTICE RENEWAL INITIATIVE.

THE VIEWS EXPRESSED IN THIS DOCUMENT ARE THOSE OF THE AUTHORS AND DO NOT NECESSARILY REFLECT THE VIEWS OF THE GOVERNMENT OF NOVA SCOTIA.

TABLE OF CONTENTS

Section 1: INTRODUCTION 2

- Overview of the Project
- Defining the Propulation of Interest
- Defining Antisocial / Conduct Disordered Behaviour
- Prevalence / Developmental Course and Costs

Section 2: SURVEY AND INTERVIEW RESULTS 14

- Provincial Survey
- Interviews

Section 3: CANADIAN INTIATIVES 22

- General Trends
- Established Programs

Section 4: BEST PRACTICE MODELS FOR ASSESSMENT 26

- Standards for Assessment
- Major Assessment Domains and Methods
- Special Considerations in Assessment

Section 5: BEST PRACTICE INTERVENTION PROGRAMS 37

- Issues in Residential Placement
- Best Practice Standards for Intervention Programs
- Characteristics of Successful Programs
- Examples of Successful Programs

Section 6: THEORETICAL BASIS FOR THE PROPOSED SERVICE 47

Section 7: PROPOSED INTEGRATED ASSESSMENT/ TREATMENT SERVICE ..52

Section 8: REFERNCES 62

SECTION 1: INTRODUCTION

Overview of the Project

This project is an initiative of the Youth Justice Multi-Disciplinary Committee, a committee of the Children and Youth Action Committee (CAYAC) of Nova Scotia. The financing of the project was provided by Justice Canada from the Provincial/Territorial Partnership Approach to Implementation (File No. 6133-5-23), a component of the Youth Justice Renewal Fund. The Partnership Component is designed to assist provincial and territorial ministries to strengthen, enhance and expand the involvement of traditional and nontraditional partners in the youth justice system.

The Mental Health Services for Young People Subcommittee of the Youth Justice Multi-Disciplinary Committee contracted the authors of this document to conduct a research study with the following goals: (1) to identify the service needs of young offenders between the ages of 12 and 18 years of age including youth within this age range who were at high risk of becoming involved in juvenile crime, and (2) to identify a "best practice" model for the assessment and treatment of these youth based upon their needs.

In order to accomplish the objectives outlined by the committee, a number of initiatives were undertaken. The first was to determine what services are currently being provided to young offenders (and conduct disordered youth) in their communities throughout the province. A survey (see Appendix A) was designed to collect general information from service providers throughout the province regarding the method of interventions most often utilized in treating these youth and the perceived success rate with these methods. The survey was sent out to persons identified as key service providers to adolescents within Mental Health, Drug Dependency, Education, Child Welfare, Group Homes, Probation, Alternative Measures Societies, and Resource Centers. In addition, key staff at the Youth Detention Centers were surveyed . A modified version of the questionnaire was distributed to Judges/Justices and Lawyers who adjudicate these youth (see Appendix B). In addition, statistical data was obtained from the Department of Justice regarding youth crime rates as well as from the Department of Health on frequency of diagnoses of Disruptive Behaviour Disorders in both community mental health clinics and inpatient mental health services for youth throughout the province, and from the Department of Community Services on residential placements for Youth in Care and Custody.

The second initiative involved making contacts with Youth Justice Programs in other provinces across the country. Youth Justice officials were contacted in a number of provinces to determine the approaches being taken across Canada with regard to this population. Three well established programs, in New Brunswick, Ontario, and British Columbia were chosen for specific review.

These programs are described in Section 3 of this report.

The third initiative was to review the research literature regarding assessment and empirically supported treatment services for severe conduct disordered and antisocial youth, with particular attention to the past 10 years. The goal of this literature review was to gather as much information as possible on clinical trials of intervention programs, including comparisons of clinical methods of intervention and general review articles critiquing interventions and identifying "best practice" models for this population. These research findings are reviewed in Sections 4 and 5 of the report.

In addition to the survey data, contact was made with professionals providing services to this population throughout the regions of Nova Scotia, to discuss the best service models proposed in the literature. This initiative was undertaken to obtain a community perspective on the level of need for these youth and to determine the degree of support for changes to service provision within rural and urban areas of Nova Scotia. Results from these interviews are described in Section 2.

From all of these sources of information, the authors provide recommendations for the provision of a community-based assessment and treatment program for youth between the ages of 12 and 18 years who are either involved in criminal activity, are at "high risk" of violent, aggressive, delinquent behaviour, or are experiencing some form of severe disruptive behaviour disorder. The proposed service addresses the methods of assessment that will identify the individual needs of these youth and a standardized format for YOA court ordered assessments. The proposed service also delineates methods of intervention and systemic changes to the way in which conduct disordered and antisocial youth could be managed. The proposal is based upon a best practice model distilled from both research and clinical practice in this area. Included in the proposal are recommendations with regard to program evaluation, staff training and prevention..

Defining the Population of Interest

This project addresses youth between the ages of 12 and 18 who commit criminal and/or antisocial acts and are either currently charged under the Young Offenders Act (YOA), or are seen as high risk to be charged under the Act. This project did not address the subgroup of young offenders charged with sex offenses as proposals for treatment programs for this subpopulation have already been undertaken and completed (see "A Community Based Adolescent Sex Offender Treatment Program for the Province of Nova Scotia: Best Practices Review & Recommendations, by Pleydon, Conners, & Woodworth, April, 2000 and "Adolescent Sex Offender Treatment Program - Draft Proposal - Modified January 3, 2001 completed by Joan Boutilier).

Youth charged with criminal behaviour are readily identified for statistical purposes through the Department of Justice, whereas youth who are at "high risk" are more difficult to define and quantify statistically. Frequency graphs of youth charged in Nova Scotia between 1999 and 2000 with various offenses are presented in Figures 1.1 and 1.2. Figure 1.1 describes the frequency of various types of criminal charges by category. The category of offense most frequency charged was Property Offenses, accounting for almost 32 % of the charges. Other criminal code offenses accounted for 21 % of the charges and violent crime accounted for approximately 11 % of the charges. Figure 1.2 describes the frequency of youth charged in Nova Scotia by region. Halifax, Dartmouth and Bedford accounted for 28.8 percent of the young people charged with offenses in this time frame. Sydney accounted for 15.2 percent of the population of youth charged. Bridgewater, Yarmouth, Truro and New Glasgow each accounted for between 8 and 9 percent of the youth charged and the other areas of Nova Scotia accounted each for less than 6 percent of the youth charged.

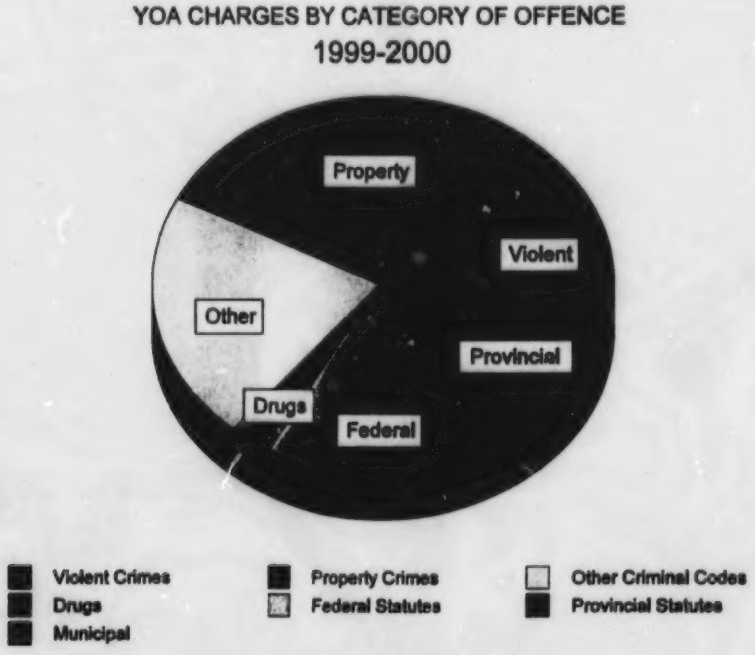

Figure 1.1. YOA Charges by Category of Offence 1999-2000

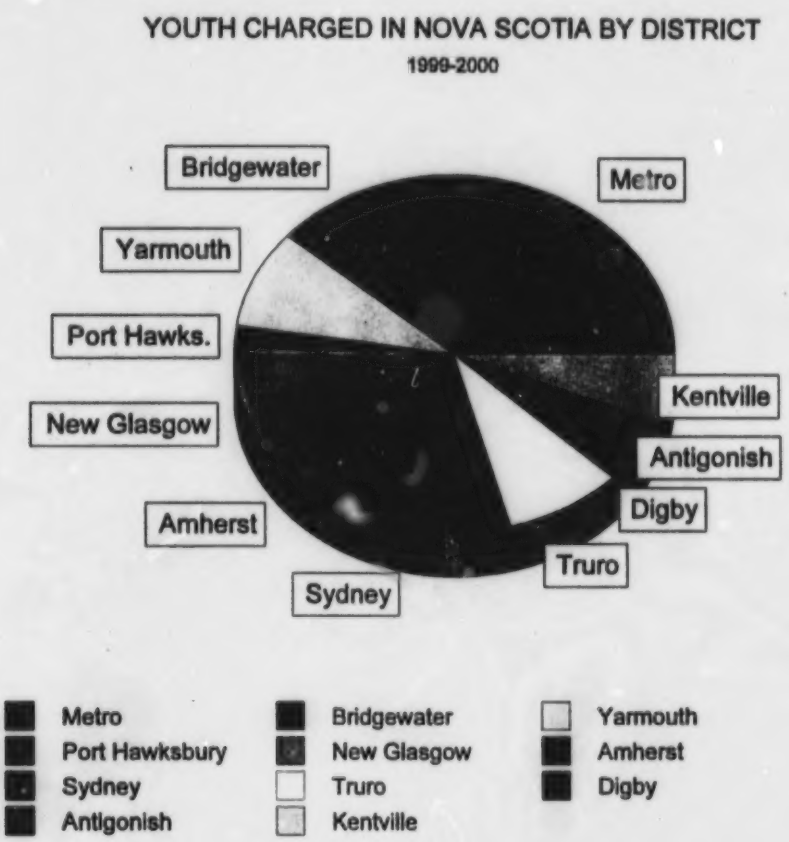

Figure 1.2: Youth Charged in Nova Scotia by District in 1999-2000

To obtain some measure of the youth who are at risk due to disruptive behaviour disorders, statistics were obtained from the Department of Health on the frequency of diagnoses of Disruptive Behaviour Disorders within both Community Mental Health Clinics that provide services to adolescents (see Figures 1.3 and 1.4).

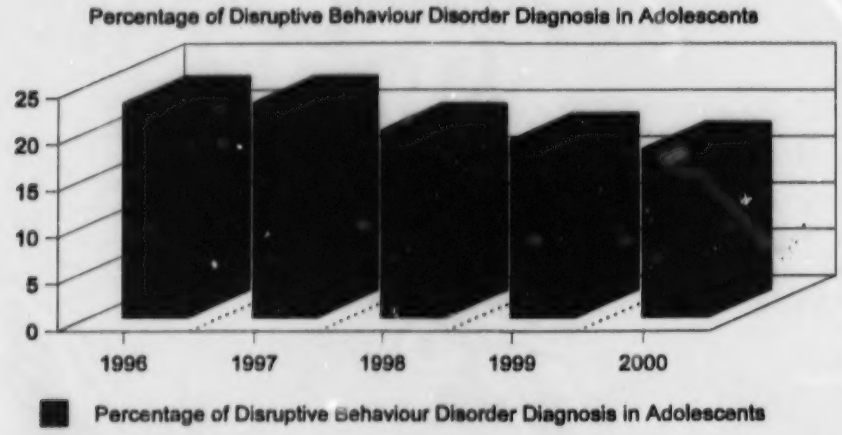

Figure 1.3: Percentage of Disruptive Behaviour Disorder Diagnosis in Adolescents referred to Community Mental Health Clinics in Nova Scotia

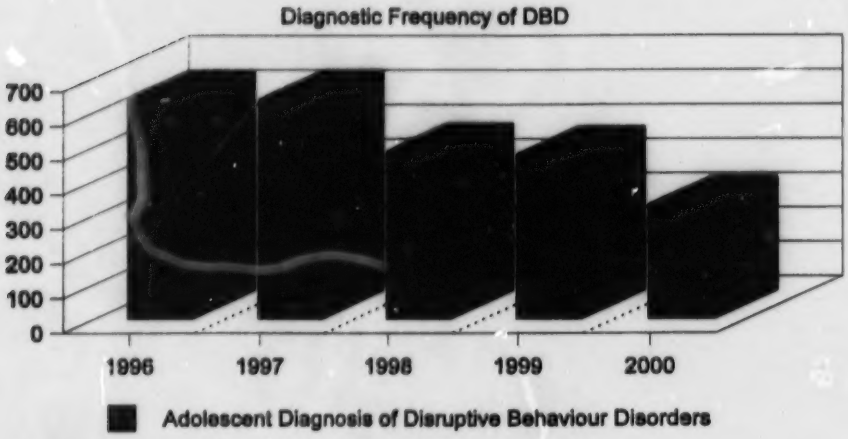

Figure 1.4: Diagnostic Frequency of Disruptive Behaviour Disorders in Adolescents seen in Community Mental Health Clinics in Nova Scotia

As these charts indicate, the percentage of youth seen in Community Mental Health Clinics who have some type of disruptive behaviour disorder has ranged between 15 and 23 % of all clinic referrals over the past 5 years. The actual numbers of youth seen at the mental health clinics in this province for these disorders has declined over the past 5 years, however this may relate to more limited access to mental health resources rather than a bias against treating this disorder, since the percentage of youth seen that have this diagnosis has not shown as dramatic a decrease.

In addition to these youth, many of whom continue to reside in their family homes, there are those youth whose behaviour has resulted in out-of-home placements. These youth are often in residential care facilities managed by the Department of Community Services, and a few of these youth, with highly disruptive behaviour, have created placement crises such that they have been placed in residential facilities out of province. Although the number of youth being placed out of province is few, these young persons are among the most disruptive and difficult to serve of the conduct disordered youth. These statistics are reported in Figures 1.5 and 1.6.

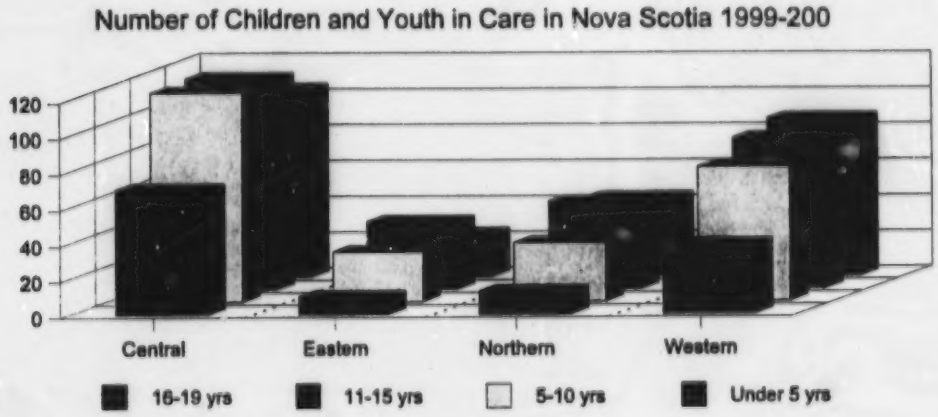

Figure 1.5: Number of Children and Youth in Care in Nova Scotia in 1999-2000 by Region

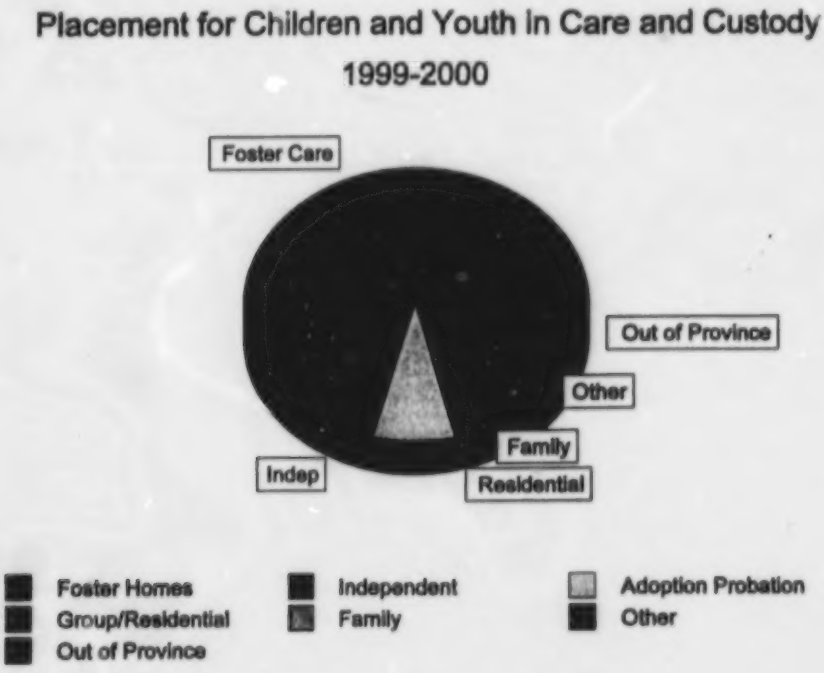

Figure 1.6: Placement for Children and Youth in Care and Custody in 1999-2000

As these statistics demonstrate, there are more youth in care after the age of 11 than before the age of 11 in Nova Scotia. Although the number of youth above age 11 in various placements was not specified, we know that youth in this age group are more likely to be living independently, or in group or residential placements than in foster families, unless they have been in care for several years. These statistics tell us that the number of youth in care in the adolescent age range is substantial (i.e., 550) and many of these youth are in licensed children's residential beds in this province. The province has 217 licensed residential beds for children and youth. In the year reported (i.e., 1999-2000), 28 youth were reported to be placed out of province. These youth are usually the most behaviourally difficult youth for the Department of Community Services.

Cummings, Singer, & deBois, 1981). However, only about 40 % of conduct disordered youth are diagnosed with severe antisocial problems as adults (Wadell, Lipman &Offord, 1999; AACAP, 1997).

Youth with Disruptive Behaviour Disorders demonstrate aggressiveness, a lack of empathy and diminished skill at social problem solving. They misperceive the social environment, often attributing hostile intentions to others (Lockman & Dodge, 1994). Anger and irritability are the major mood states of conduct disordered youth (Brosnan & Carr, 2000). They are more often involved in substance use and abuse and more often involved in superficial sexual contacts. In addition, these conduct disordered youth may be diagnosed with other comorbid disorders including affective disorders and anxiety disorders (Altepeter & Korger, 1999; Santor & Kusumakar, 1999). Offord and Bennett (1994) indicate that the factors that tend to be associated with the persistence of conduct disorder into adulthood are early age of onset, and high rates of problem behaviours displayed in multiple settings. There is a high frequency of of various forms of learning disability within this population of juvenile offenders as well (Offord & Bennett, 1994).

If these antisocial youth reach the Justice system they will be labeled an "offender" (a term which replaces the older term "delinquent"). Under the Young Offender Act a Youth can no longer be charged with an offense which would not be considered illegal at all if not for the youth's age (e.g., alcohol use, tobacco use, school truancy, staying out late, running away, and persistent rule violation). The youth can be charged with criminal offenses which would be illegal at any age, such as assault, rape, manslaughter, murder, robbery, burglary, major theft, and arson. Drug use is also a common form of criminal behaviour in this group of antisocial youth.

In surveys completed in the US, somewhere between 5 and 10 % of adolescents report involvement in violent crimes (Borduin & Schaeffer, 1998). Adolescents with serious and violent antisocial behaviour have certain common characteristics. Borduin and Shaeffer (1998) report that this subgroup of young offenders have lower intelligence test scores, have more social skills deficits, and have a hostile attributional bias. The families of these violent youth are more disturbed than the families of nonviolent youth. Discipline is more lax and ineffective, with poor parental monitoring of the youth, there is more likely to be a history of witnessing domestic violence in the home and the violence in the families is likely to be more chronic. Violent youth have a high percentage of assaultive behaviours carried out with peers, although positive family interactions can mitigate the influence of a negative peer group (Erickson, Crosnoe, & Dornbuson, 2000). Violent youth perform poorly in school and drop out of school early. They often come from neighborhoods where there is a higher frequency of community violence, a higher crime rate, greater access to weapons and drugs, and where youth are often the victims of community violence (Borduin, Heiblum, Jones, and Grabe, 1998). Borduin and Schaeffer (1998)

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conclude from a review of longitudinal research, that violent and chronic offenders are at increased risk of committing serious and repeated crimes during adulthood.

It should be noted that not all youth who commit crimes will reach the criteria for a diagnosis of a Disruptive Behaviour Disorder, and not all children and youth with Disruptive Behaviour Disorders will come into contact with juvenile justice. However, there is considerable overlap in the antisocial acts of youth who come into contact with mental health and justice and their treatment needs are largely the same (Henggeler et al, 1998). These youth are also likely to come to the attention of Child Welfare agencies due to a lack of parental child management skills and out-of-home placement issues which arise regularly with these youth (Lipsey & Derzon, 1998).

Prevalence / Developmental Course and Costs Associated with Conduct Disorder

The prevalence of conduct disorder among community samples is somewhere between 2% and 6% of the population. Conduct disorders constitute a third to a half of all clinic referrals and chronic conduct problems are the single most costly disorder of adolescence according to Kazdin (1995). The diagnosis is 3 to 4 times more prevalent in boys than in girls. The prevalence of Conduct Disorder is higher in the age group between 12 and 17 years of age, than it is in children between 4 and 11 years of age, i.e., 7% versus 4 % (Kazdin, 1998). Conduct Disorder is relatively common in Canada as well. Approximately 5.5 % of Ontario children between the ages of 4 and 16 have this disorder and it is the most common reason for referral to child psychiatry services in North America (Waddell, Lipman, and Offord, 1999).

Criminal and antisocial behaviour in youth exacts a tremendous toll on society, taxing limited financial and human resources at all levels of government, in order to provide correctional services, rehabilitation services, legal services, mental health services, and residential services to these youth. For example, it costs about $95,000 a year to hold a youth in secure custody in Canada (Waddell et al., 1999). The social burdens of juvenile crime and serious antisocial behaviour are in addition to the impact that juvenile crime has on the victims of that crime, physically, financially and emotionally (Henggeler, 1996), as well as the impact that the behaviour has on the mental health and well being of the families of these youth. Finally, failure to intervene effectively with these youth has a long term impact on society when criminal behaviour is continued into adulthood.

Kazdin (1995) provides several reasons for the cost associated with conduct disorder. First conduct disorder is largely unresponsive to traditional treatment approaches. Secondly, the course of the disorder for 60 % of youth is a poor outcome characterized by continued involvement in antisocial acts, development of an antisocial personality, substance abuse problems, lack of educational attainment, occupational problems, marital instability, and social problems. The third cost factor associated with conduct disorder is the inter-generational

transmission of antisocial behaviour through transmission of antisocial values and repeated poor parenting practices. Kazdin indicates that difficult temperament, aggressiveness, impulsivity and inattentiveness, and educational difficulties were the main personal characteristics of adolescents who are at risk for long term conduct problems. Ineffective monitoring and supervision of adolescents, inconsistency with consequences, and failing to reward prosocial behaviours were the main problematic parenting practices that placed adolescents at risk for long term conduct problems. Parental conflict and violence, high levels of life stressors, a low level of social support and parental psychological adjustment problems also were risk factors for continuation of antisocial behaviour into adulthood. The poor outcomes cited for 50 to 60 % of conduct disorder youth, speaks to the need for interventions that will target not only the symptoms of Conduct Disorder behaviour but also the factors in the youth's environment that maintains and sustains the antisocial behaviour (Gorman-Smith, Tolan, Zeli, and Huesmann, 1996; Gordon et al., 1998)

The majority of the violent and serious crimes perpetrated by young offenders are committed by a small percentage of antisocial youth but account for a disproportionate amount of crimes in their communities (Henggeler, 1989). The public service systems that are responsible for these youth and their care, namely, juvenile justice, child mental health and child welfare, utilize interventions that have failed to address the needs of this population (Schoenwald, Scherer, and Brondino, 1997; Gordon, Jurkovic & Arbuthnot, 1998). Henggeler (1996) contends that while the relevant targets for intervention are obvious from the literature (i.e., treatments should address the individual, family, peer, school and community issues in an integrated fashion), clinicians in practice do not use this multidimensional approach either because the types of interventions are not in keeping with office based practice or they are viewed as too expensive by those who fund the services.

A review of the treatment literature with young offenders and conduct disordered youth suggests that community based care for serious conduct disordered and antisocial youth has been ineffective because it has been limited to disjointed attempts to address one or more aspects of the youth's functioning in isolation or in ignorance of other impinging factors that sustain antisocial behaviour for the youth. The traditional alternative to community based care has been the more restrictive and expensive alternatives of residential treatment, psychiatric hospitalization, and incarceration. These alternatives are extremely expensive and have virtually no empirical support for their effectiveness (Henggeler & Santos, in press as cited Henggeler, 1996). The literature that addresses the outcome for residentially housed youth clearly shows that antisocial behaviour is not reduced and that positive life outcome is not enhanced as a result of the residential care. This is not a criticism of residential care facilities, but rather it is a statement about where resources need to be invested in order to be cost effective and to effect behavioural changes that will be transferred to community life. Clearly community-based treatments are essential to meeting these goals, either an alternative to institutional care or as a follow-up after institutional

care. Failure to address the natural ecology to which the youth will be returned eventually undermines the effectiveness of any out of home placement, regardless of clinical interventions and services that the youth may have received while in residential care.

SECTION 2 : SURVEY AND INTERVIEW RESULTS

Provincial Survey

As part of the present study, a survey was developed and distributed across the province to service providers who were viewed as likely to have regular contact with at-risk youth. These service providers included representatives from child welfare, mental health, education, drug dependency, as well as workers in various facilities, group homes and resource centers. A slightly modified survey was distributed to lawyers, prosecutor and judges who have regular contact with young offenders. There was no attempt to maintain any scientific rigor with regard to the distribution of this survey. Individuals were encouraged to photocopy the survey and distribute it within their agency or facility, or to others working with at risk youth. Therefore, it is not possible to determine an exact return rate. However, approximately 300 surveys were mailed out, with 156 returned from agencies and facilities and 26 returned from lawyers, prosecutors and judges. A list of the agencies and facilities represented by the returned surveys is found in Appendix C.

The purpose of the survey was to identify issues around the delivery of services to youth at risk of becoming involved in the criminal justice system. Specifically, it was hoped that through this survey, services currently in place for this population could be identified, along with issues associated with present service delivery. As well, individuals completing the survey were asked to identify service gaps or needs for youth at risk.

Statistical analysis of survey results was limited to completing summary statistics, which can be found in Appendix D. Surveys returned were fairly evenly distributed across agencies and facilities (see Figures 2.1 and 2.2).

Survey results indicate that most respondents viewed youth involved with or at-risk of becoming involved with the criminal justice system as constituting a fairly substantial percentage of the population they served. Understandably, respondents within Education indicated that at-risk youth constituted the smallest percentage of youth served, with the modal response being less than 5%. At the other end of the continuum, respondents from Probation, Youth Detention Centers and Youth Resource or Alternative Measures programs indicated that virtually all youth they served were within the at-risk group (modal response 100%). Respondents from other groups consistently indicated that youth within the at-risk group were represented in large numbers among youth served. The modal responses were as follows: Child Welfare Agencies - 26-50%; Drug Dependency - 51-99%; Mental Health - 11-25%; Group Home/Residential Centers - 51-99%. Despite the fact that these youth constitute a large percentage of the population served

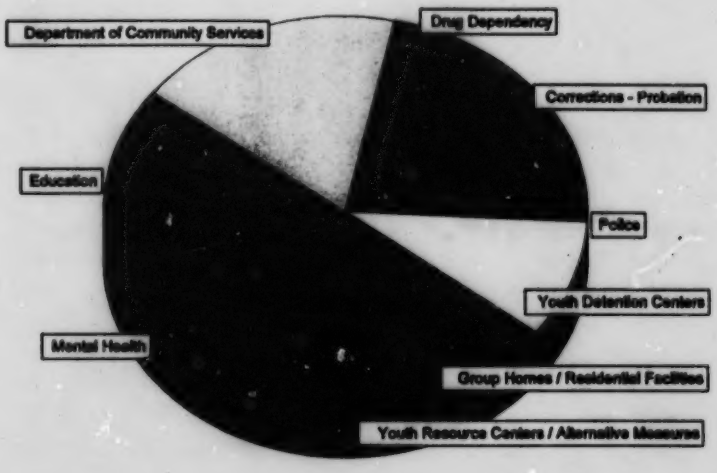

Figure 2.1: Percentage of surveys received by agency represented.

Figure 2.2: Percentage of surveys received from legal services.

by most respondents, most respondents indicated that there was not a specific agency or facility policy to deal with youth involved in the criminal justice system (except for the criminal justice system itself).

With regard to assessment of youth at-risk, four mental health problems were consistently identified as in evidence. These were substance abuse, social skills problems, anger problems and family dysfunction. As well, judges responding indicated that antisocial attitudes were also frequently present. There was some consistency in identifying environmental factors common among at risk youth. School underachievement, poor parental supervision and antisocial peers were identified as issues for most respondents. Of note is the fact that among respondents directly involved in the justice system, antisocial family role models were also frequently identified as an environmental concern. Another important point that comes from the survey is that, while psychiatric and psychological assessments are routinely requested by judges, prosecutors and defense lawyers, such assessments tend not to be provided by the agencies responding to the surveys. The percentage of respondents indicating that they refer outside their own agency or facility for assessments ranged from 57% among mental health respondents to 100% among child welfare respondents.

With regard to treatment services, only a small number of respondents (ranging from 17-40% across agencies) outside of the justice system indicated that their agency offered specialized programs for anti-social youth. Services consistently endorsed by judges, prosecutors and lawyers as being helpful were: In Home Services, Psychiatric Follow-up, Inpatient or Residential Treatment and Substance Abuse Counseling. The most preferred intervention strategies across agencies were: Behavioural Management, Substance Abuse Counseling, Parent Training or Support, Supportive Counseling and Anger Management. Most agencies indicated that there was not a standard evaluation process with regard to intervention strategies provided. Most respondents indicated that they referred outside their agency or facility for some types of treatment services. However, waiting lists were identified as an obstacle to obtaining services by 80% of respondents.

Judges, prosecutors and lawyers were unanimous in the opinion that a protocol for working across agencies and services was necessary for good service delivery. Among respondents from agencies and facilities, 46% indicated that such a protocol was in place. However, there was a wide range across agencies and facilities, with about 70% of justice oriented respondents indicated that such protocols existed, while only 34% of other respondents identify the existence of such protocols. Comments regarding this particular question suggest that many of the protocols referenced are informal. Many respondents who wrote comments stressed the importance of collaboration across services.

Finally, an overwhelming number of respondents (95%) from agencies and facilities indicated that

there was a gap in services to at risk youth. This was echoed by judges, prosecutors and lawyers, 100% of whom indicated that such a service gap existed. Respondents were asked to describe the types of programs or services envisioned for youth at risk, "to ideally address their service needs." The comments were reviewed and placed in broad categories across eight groups of respondents (Probation, Drug Dependency/Mental Health, Child Welfare, Education, Resource Centers/Alternative Measures, Group Homes/Residential Facilities, Detention Centers, and Judges/Lawyers). The most frequently mentioned types of services for each category are found in Table 2.1 and 2.2. As can be seen, there is a remarkable degree of consistency among the top ranked services. Three areas stand out as being mentioned by nearly all groups. These are the need for increased mental health services, the need for inpatient or residential facilities for at risk youth and the need for greater collaboration between agencies.

The need for additional mental health services was frequently mentioned in all groups, with the exception of respondents working in correctional facilities. Within this category, a broad range of specific services, ranging from anger management groups to day treatment programs were mentioned. However, the unifying factor was the opinion that present mental health services were inadequate. In addition, comments were often directed at the need to develop more innovative and flexible programs for this population.

It is very apparent from comments to this question that there is a perceived need for residential or inpatient facilities for youth at risk. Again, a variety of services were described, including secure treatment facilities, long-term residential programs, specialized inpatient assessment units and additional group living facilities for adolescents. The common theme within this category of comments was the difficulty in placing adolescents with behavioral problems who are not able to live at home. As one mental health professional wrote, "these youth are very physically aggressive requiring restrictive intervention. Present residential facilities are unable to contain them. Consequently, their emotional behaviours are criminalized and they return to the justice system."

A strong need for better collaboration between service providers was also emphasized. Many respondents pointed out that youth at risk and their families often have multiple agency and/or professional involvement and that there is typically a lack of comprehensive and coordinated planning. This sentiment is voiced well in one judges comment that "There needs to be a multi-disciplinary network of community based services as will be grounded on an assessment of risk and awareness of resources available in the community. Programs and departments have to collaborate and cooperate across department boundaries. It is only through cooperation across disciplines that a comprehensive system of care will be created."

Finally, a number of other service needs were mentioned on a fairly consistent basis. Several groups commented on the need for treatment services for adolescent sex offenders. The need for

Table 2.1: Most Frequently Identified Service Needs for Youth at Risk Ranked by Respondent Group

Probation

1. Residential/Inpatient Facilities
2. Mental Health Services
3. Collaboration between Services
4. Drug/Alcohol Counseling

Child Welfare

1. Residential/Inpatient Facilities
2. Collaboration between Services
3. Mental Health Services
4. Prevention/Early Intervention
5. Family Therapy

Resource Centers/Alternative Measures

1. Mental Health Services
2. Collaboration between Services
3. Education Programs

Detention Centers

1. Community Based Programs
2. Family Therapy
   Collaboration between Services
   Sex Offender Programs

Drug Dependency/Mental Health

1. Residential/Inpatient Facilities
2. Collaboration between Services
3. Mental Health Services
4. Education Programs
5. Sex Offender Programs

Education

1. Education Programs
2. Mental Health Services
3. Collaboration between Services
4. Parent Programs
5. Residential/Inpatient Facilities

Group Homes/Residential Programs

1. Mental Health Services
2. Education Program
3. Sex Offender Programs

Judges/Lawyers

1. Inpatient/Residential Programs
2. Mental Health Services
3. Prevention/Early Intervention
   Collaboration between Services
   Drug/Alcohol Counseling

Table 2.2 Most Frequently Identified Priority Service Needs

A copy of this table is available in hard copy from the authors of the report.

specialized educational programming, including assessment for learning difficulties, was also mentioned on numerous occasions, as was the need for prevention and early intervention programs and drug and alcohol services, particularly at a local service level. In general, respondents to the survey provided a comprehensive description of ideal services for this population.

Interviews

Following the collection of data from surveys and the review of relevant literature with regard to assessment and treatment of youth at-risk, personal interviews were conducted with a number of individuals identified as having particular interest in the area of services for anti-social youth. These interviews were conducted in all regions of the province (see Appendix E for a list of participating agencies) with the purpose of obtaining additional information regarding concerns around assessment and treatment services for at-risk youth. As well, these interviews provided an opportunity for the researchers to describe possible service models and receive feedback as to how such services might work on a local level.

A number of issues were consistently raised in these interviews. Foremost was the almost unanimous agreement that there was a serious lack of services for antisocial and conduct disordered youth. With regard to court ordered assessments, it appeared that outside of the Metro area, such assessments occur infrequently. It was suggested that this was due, in part, to a lack of professionals to complete such assessments. Several individuals suggested a need for an impatient assessment unit for this purpose.

Treatment services were also viewed as seriously lacking. It was noted that long waiting lists were the standard for mental health services. Probation workers pointed out the lack of funding for treatment when such treatment was ordered as part of a youth's probation. Consequently, this part of the probation order was often not followed, unless the family could afford a private practitioner. Child welfare workers reported a strong reliance on private practitioners for providing assessment and treatment with children in care. It was suggested by some mental health professionals that this created a two-tiered mental health service, with children in care having more opportunities for treatment services than children not in care. Some specific treatment services were advocated on a number of occasions. These were residential or secure treatment and treatment for sex offenders.

Placement for conduct disordered or antisocial youth was described as an ongoing problem. Many child welfare workers described a "crisis" with regard to placement for these youth. It was noted that foster placements are rarely available and that group home facilities rarely have the resources to deal with severely disruptive youth. It was noted that a lack of placement sometimes

resulted in inappropriate remands to correctional facilities.

Linkages between correctional facilities and local communities was also described as problematic. It was reported that there was little communication between facilities and local workers. As noted, inappropriate remands were of concern. Aftercare issues were also described. It was suggested that there was little in the way of coordinated planning for youth released from facilities.

This lack of coordination was also evident at a local level. Although most interviewees described good cooperation among service providers on an informal or case by case basis, there were few instances of formalized, integrated service approaches noted. Some interviewees suggested that there continued to be turf issues and a general reluctance to deal with this population which interfered with cooperative efforts.

The need for prevention and early intervention efforts was cited by many interviewees. An example of an effective early intervention program described by a number of individuals is the BEST program (Behavior Education Support Treatment) which operates in the Northern Region of Nova Scotia (Thurston, Colquhoun, & Waschbusch, 2001).

Finally, when discussing the development of services for conduct disordered and antisocial youth, most interviewees responded in a positive manner to the idea of a specialized program. It was made very clear, however, that any new program would need to be adequately resourced. The need for additional staff, additional space and specific training was noted. It was suggested that local input was important and in some regions, issues of accessibility were viewed as key. The idea of local, multisystemic, family oriented services was met with a positive response, with many interviewees noting that local services were moving in a similar direction.

SECTION 3: CANADIAN INITIATIVES

General Trends

Contact was made with a number of youth justice officials across Canada in order to get a sense of how the needs of this population were being addressed in other jurisdictions. These contacts were completed on an informal basis. There was no attempt to identify relevant programs in all provinces. Rather, a sampling of provincial officials and professionals working in specific programs were contacted (see Appendix F). The following generalizations are based on contacts with individuals in New Brunswick, Ontario, Saskatchewan and Alberta. In addition, three well established programs in New Brunswick, Ontario and British Columbia were examined in some detail.

Community Based Services. It is apparent that across Canada, in response to new legislation, programs are being developed with a community emphasis. These initiatives take a variety of forms. In Alberta, for example, transition workers are being hired to develop "wraparound" services for young people leaving institutions. In New Brunswick and British Columbia, an emphasis is placed on community ownership of treatment plans for youth. The recognition is that services which operate within the youth's normal community structure are more likely to have success.

Multi-systemic Models. Programs in place or being developed emphasize the need to address the multiple factors which contribute to anti-social behaviour. Again, such programs take a variety of forms, ranging from intensive multi-faceted assessment and case-planning, to intensive treatment programs which are based on social-ecological models.

Intensive Supervision. A number of provinces, including Nova Scotia are piloting or operating intensive supervision programs. These programs reflect the move toward community based and multi-systemic models and are intended as an alternative to custody. Workers tend to have small caseloads of young offenders who are followed closely. Families are involved and community resources enlisted. Ultimately, however, they remain supervision models, with the consequent court ordered conditions and constraints.

Standardized Assessment and Case Management. Within the departments of Justice in provinces contacted, there was a trend toward the development of standardized assessment and case management tools. Most jurisdictions were using the Level of Services Inventory, or some

variation of this tool. In Saskatchewan, for example, this measure is in the process of being modified to suit provincial needs. It was suggested that a case management strategy which focused on strengths rather than solely on deficits was desirable.

Standardized Treatment Approaches. Some provinces are also developing treatment standards with regard to providing interventions for young offenders. There is a recognition of the need to establish standards for treatment practices while maintaining flexibility in service delivery.

Inter-agency Cooperation. The importance of establishing good working relationships across the multiple agencies encountered by anti-social youth and their families was emphasized. The key government agencies which must be included in a collaborative process include Education, Child Welfare, Mental Health and Youth Justice. In some jurisdictions, individual government departments independently developed services for such youth and this resulted in a duplication and lack of coordination of some services.

Established Programs

Three provincial programs, the Response Program in British Columbia, the Provincial Youth Treatment Program in New Brunswick and the Multisystemic Treatment Program in Ontario are described below. These are programs which have addressed many of the issues described above, which are well established, and which have some evaluation component.

Response Program. The Response Program operates out of the Maples Adolescent Centre in Burnaby, British Columbia and has been described in several articles (Holland, Moretti, Verlaan, and Peterson, 1993; Moretti, Holland, and Peterson, 1994; Moretti, et al., 1997). It operates from an Attachment Theory model and is designed to intervene with a youth's entire environment. As such, it does not advocate a single type of intervention as critical in meeting the needs of anti-social youth. At the central facility in Burnaby, two six-bed inpatient units accept referrals from local mental health agencies. Adolescents remain on the units for twenty-eight days, with the first three weeks devoted to assessment and the last week devoted to case planning. A central feature of the Response Program is the development of a Care Plan at the end of the third week in the program. This plan is developed at an open meeting involving all individuals who have a role in the youth's care, including social service and school representatives. It is the intention of this meeting to understand the problems of the youth in their social environment. The care plan addresses issues around the youth's lifestyle, home life and school. A second meeting is held at discharge and at this time the care plan is reviewed and issues around implementation are discussed. The Response Program makes a commitment to the youth post-discharge to "assist the community in interpreting the care plan" (Moretti, et. al., p.641) and also provides respite care to youth in order to preserve a placement.

Follow-up evaluations of the Response Program have been positive. A common concern has been the ability of communities to maintain the care plan with limited resources. Fragmented services for youths and families have created obstacles in coordination of services and a tendency for service providers to be oriented toward protecting limited resources. As well, attempts to move the program into communities has led to some resistance to the perceived intrusion of outside experts.

Provincial Youth Treatment Program. The Provincial Youth Treatment Program operates in New Brunswick and is described by Moretti, Emmrys, Grizenko, Holland, Moore, Shamsie, and Hamilton (1997). It is modeled on the Response Program, in that it is based on Attachment Theory and has as a central component, a six-bed assessment unit (i.e., the Pierre Caissie Centre). However, the New Brunswick Program has two additional components, Regional Teams representing the thirteen health regions in the province and a three member Provincial Team. The Regional Teams were originally composed of members from Mental Health, Social Services and Education. Subsequently, participation from Public Safety (comparable to Justice, in Nova Scotia) was invited. The Regional Teams are meant to develop expertise in the area of conduct disorder and to serve as a primary resource in local communities for this population. As well, the Regional Teams serve as gatekeepers to the Inpatient Unit: only youth referred by the Regional Teams are admitted to the Pierre Caissie Centre. The Provincial Team provides co-ordinating functions, consults to the Regional Teams and provides clinical direction at the Pierre Caissie Centre. Youths are admitted to the Centre for 34 days. The objective is to determine obstacles which have prevented the youth and family from benefitting from local services and to come up with recommendations that are feasible for the regional teams. Draft recommendations are sent to the Regional Teams at week three and of the youth's admission and a case conference is held at week four to discuss issues raised by the Regional Teams. As an additional service, respite is provided for youth who have previously been admitted to the Centre.

Professionals interviewed who are working within the New Brunswick Program described several challenges which have been faced. It has been somewhat difficult to bring Public Safety (i.e. probation officers) onto the regional teams, as they were not part of the process at the outset. The Regional Teams have developed with varying success. Where there has been frequent turnover among team members, the desired level of expertise has not been attained. Originally, members of the Provincial Team attended Regional Team meetings. This resulted in a high demand on Provincial Team members time and a dependency on the part of some of the Regional Teams. When the Provincial Team members representation on Regional Teams was discontinued, it had a destabilizing effect on some of the Regional Teams. Although an evaluation of the program was completed, the results of this evaluation have not been made available. Anecdotally, it is reported that communication between the participant agencies has improved.

Multisystemic Therapy (MST). In London, Ontario, clinical trials of Multisystemic Therapy (MST) are being run through the London Family Court Clinic (Leschied & Cunningham, 2001). MST uses a family preservation model, in which services are intensive, home based, goal oriented and time limited. The ultimate goal is to allow the family to assume responsibility for making and maintaining gains. Nine "guiding principals" guide the MST therapists in completing this task. Detailed information regarding MST is described elsewhere in this report. In Ontario, adolescents chosen for the clinical trials were identified to have had a high or very high risk of future criminal offending. The Level of Service Inventory was used in determining risk. Results available from these trials indicate that MST participants showed moderate positive results when compared with adolescents who were provided with "usual services." It was suggested that the somewhat less dramatic results compared to MST studies conducted in the United States were an artifact of the higher quality of "usual services" found in Ontario. Despite less striking comparative results in Ontario, a preliminary analysis of cost effectiveness of the different outcomes of "usual service" versus "MST" suggests that the costs incurred by the increased recidivism of the "usual service" group far exceeded the costs of MST intervention.

Contact with the principal investigators in the London study revealed a number of issues inherent to the delivery of MST. It was reported that MST was a very difficult intervention to implement. Delivery of the MST program is described as requiring "a complete paradigm shift" and it was reported that it takes about a year to achieve a high level of competence. The MST program is also described as having a high level of initial cost. The involvement with the originators of MST, in South Carolina, was described as necessary and as costing approximately $45,000 in consultation and training fees. It was emphasized that this supervision and training is essential to maintain a high degree of rigor and treatment fidelity. The analogy used was that trying to run a variation of MST without all components was like "a car with two wheels." The Ontario investigators were quite firm in the assertion that programs, such as the Intensive Supervision Programs being developed in various jurisdictions, may reference MST in describing the rationale for service delivery but that such programs are "very different from MST." The choice of therapists was described as crucial and it was noted that clinicians need not be master's level, but needed to be "systemically driven." In Ontario, the issue of how to choose appropriate clients is continuing to be discussed.

SECTION 4: BEST PRACTICE MODELS FOR ASSESSMENT

Standards for Assessment

A comprehensive assessment is required to clearly understand the nature and dynamics of a particular youth's antisocial behaviour, as well as the contributing environmental and personal factors related to the antisocial behaviour, which then will lead clinicians to select appropriate intervention strategies to reduce that behaviour. Experts on the assessment of young offenders and conduct problem youths argue that one of the best methods of evaluating these issues is through the use of broad-based psychological assessments (e.g., Hinshaw & Zupan, 1997; Hoge & Andrews, 1996, Hoge, 1999). Broad-based assessments focus not only on contributing factors within the youth, but also requires an evaluation of the youth's family dynamics, school functioning, peer relationships, and other environmental factors (e.g., neighbourhood, culture) that may potentially impact on their behaviour. Hence, a multidimensional approach to assessment is recommended (American Academy of Child & Adolescent Psychiatry, 1997; Hinshaw & Zupan, 1997).

Halikias (2000) has recently recommended a general structure for the forensic evaluation of youths involved with the criminal justice system. These guidelines are similar to the assessment guidelines for conduct disordered youth developed by Waddell, Lipman, and Offord (1999) for Canadian professionals and those of the American Academy of Child and Adolescent Psychiatry (1997). To summarize these guidelines, the assessment begins with the mental health professional seeking to understand clearly the purpose of the assessment they have been asked to conduct. Once the purpose of the assessment has been clarified, the task of the assessor is to obtain as much information as possible about the youth's social, developmental, medical, academic, criminal, and mental health history that is relevant to address the referral question. To achieve this multidimensional perspective, the assessment of antisocial youth should include multiple methods of information gathering (interviews, psychometric testing, file review), use multiple informants (e.g., parents, teacher, probation officer, social worker), and should include multiple settings (e.g., home, school, community; American Academy of Child & Adolescent Psychiatry, 1997). Based on a systematic evaluation of the obtained information, the assessor should be able to identify the contributing, risk, and protective factors that impact on the youth's general functioning and antisocial behaviour. Case formulation should identify targets for intervention and form the foundation of case management, planning, and recommendations. To be useful, it is important that recommendations be practical and fit the resources available to the youth (Halikias, 2000).

Various methods of gathering information for an assessment exist and a combination of these approaches is likely to yield the most balanced and meaningful perspective on the youth and his or

her situation. Specifically, useful information can be obtained from a thorough review of case file information (e.g., school records, mental health records, criminal records, medical records), interviews with the youth, family, school staff, and other relevant parties (e.g., social workers, probation officers, youth workers), and psychometric testing (self-report and objective measures). When combined with other sources of information, Halikias (2000) argues that psychometric testing can increase the convergent validity of the information obtained and decrease the possibility of errors. Hoge and his colleagues (Hoge, 1999; Hoge & Andrews, 1996) strongly argue that any psychometric measure used should be standardized and empirically supported in order to enhance the validity of the information obtained.

In forensic and clinical settings that deal with antisocial youth, clinicians are often asked to evaluate the contributors to a youth's antisocial behaviour, estimate the risk of future antisocial behaviour and violence, and to provide recommendations for intervention to reduce that risk. One of the more efficient methods of addressing these questions is a through a risk/need assessment, which can be achieved through the methods and guidelines reviewed above. According to Andrews and Bonta (1998), a risk/need assessment of antisocial individuals should follow three major principles. The risk principle calls for the evaluation of an individual's level of risk for involvement in future antisocial behaviour and identifies factors contributing to that risk. The need principle focuses on the evaluation of individual dynamic factors (needs) that may be targeted for intervention in an effort to reduce risk (e.g., substance abuse, poor anger controls). The responsivity principle is concerned with gaining an understanding of the aspects of the individual and his or her environment that may impact on their response to intervention (e.g., family resources, intellectual level). Attention to responsivity issues helps to ensure that intervention strategies are appropriately matched to the individual's level of risk, resources, cognitive functioning, and learning abilities. Collectively, these three principles help to guide decisions pertaining to assessment, case management, and treatment planning to best meet the youth's needs.

Major Assessment Domains & Methods of Assessment

Reflecting the multi-determined nature of antisocial behaviour, there is substantial variability among antisocial youths (e.g., Halikias, 2000; Lahey, Loeber, Quay, Frick, & Grimm, 1997). However, despite this heterogeneity a number of consistent individual, family, social, academic, and community risk/need factors have been associated with antisocial and violent behaviour (for reviews see Andrew, 1981; Andrews, 1989; Loeber & Dishion, 1983, Loeber & Farrington, 1998; Moffitt, 1993; Moffitt et al., 1996; Stouthamer-Loeber & Loeber, 1988). As shown in Table 4.1, some of the more consistent of these factors include family dysfunction and poor quality parenting (e.g., family violence, poor parenting skills, poor family relationships), problems with academic adjustment (e.g., academic problems, disruptive behaviour), history of early conduct problem behaviour (e.g., aggression, lying, stealing, criminal history), substance abuse, poor social skills, association with antisocial peers, and adherence to values and beliefs that are supportive of

Table 4.1: Correlates of Antisocial Behaviour and Violence in Youths.

Demographic Factors

- Being male[1, 2]
- Low family socio-economic status[2]
- Minority ethnicity[2]

Family Background Factors

- Family conflict/dysfunction[1, 2, 6]
- Low level of affection or cohesiveness/poor parent-child relationship[1, 4, 5, 6]
- Separation from parents/parental absence[3, 4]
- Family violence[1]
- Child neglect and inconsistent discipline/supervision[6]
- Poor supervision and discipline[1, 3, 4]
- Antisocial parents/parental criminality[1, 2, 3, 6]
- Parental substance abuse[1]

Social Factors

- Antisocial peers/associates during adolescence[1, 2, 4, 5]
- General difficulties in relationships with others, especially during adolescence[1, 2]
- Poor use of leisure and recreational activities[1]

Behaviour Factors

- Conduct problems (e.g., aggression, lying, stealing, truancy, impulsivity, early sexual behaviour, substance use, risk taking behaviour)[1, 2, 3, 4, 5]
- Early and diverse developmentally inappropriate misbehaviour displayed in a variety of settings (stealing, lying, aggression)[1, 4, 6]

Attitudes

- Attitudes & values supportive of antisocial behaviour, violence and antiauthority[1, 5, 6]

Competency Factors

- Below average intelligence[1]
- Poor self-management & problem solving skills[1]

Academic Characteristics

- Poor School Performance and Achievement[1, 2, 3, 4, 5, 6]
- Problematic Behaviour in School[1, 2]

Community Factors

- Poverty[6]
- Availability of drugs[6]
- High crime neighborhood[6]

Note. This table is based on a literature review by Andrews (1989)[1] and meta-analytic and systematic reviews on the predictors of antisocial behaviour and violence, including Lipsey & Derzon (1998)[2]; Loeber & Dishion (1983)[3]; Stouthamer-Loeber & Loeber (1988)[4], Simourd & Andrews (1994)[5], and Hawkins et al., (1998)[6].

antisocial behaviour. Although these factors are inter-related, the consensus is that the more of these risk/need factors present, the greater the risk of antisocial behaviour (e.g., American Academy of Child & Adolescent Psychiatry, 1997). Hence, professionals should be aware of the various factors that can influence the development and course of antisocial behaviour and of the most efficient methods of evaluating these risk/need domains. A brief review of the domains and some of the measures used to assess them is presented below.

Assessment of Family Functioning & Parenting Styles. An examination of family functioning can provide useful information regarding a youth's risk of future antisocial behaviour (Hoge, Andrews, & Leschied, 1994). Specifically, family dysfunction and poor parenting practices, especially harsh and inconsistent parenting, have often been linked to the development and persistence of antisocial behaviour (Andrews, 1989; Lipsey & Derzon, 1998; Loeber & Dishion, 1983; Stouthamer-Loeber & Loeber, 1988; Waddell et al., 1999). Hence, the assessment of antisocial youths should include a thorough evaluation of the family environment, including the quality of the parent-child relationship, parenting behaviours, characteristics of the family dynamics, and determination of family resources (Munger, 2000). This evaluation should also determine whether family violence and marital conflict are a concern.

Hoge and Andrews (1996) have recommended a number of standardized measures of general family functioning for use with antisocial youth. Examples of these measures are the Family Adaptability and Cohesion Scales - II (Olson, Partner, & Lavee, 1985), the McMaster Family Assessment Device (Epstein, Baldwin, & Bishop, 1983), the Family Assessment Measure III (Skinner, Steinhauer, & Santa-Barbara, 1983), the Family Beliefs Inventory (Roehling & Robin, 1986), the Family Environment Scale (FES; Moos & Moos, 1986), and the Family Events Checklist (Patterson, Reid, & Dishion, 1992).

More specific measures have been developed for the purpose of assessing parenting skills and the quality of parent-child relationships. These include the Children's Report of Parental Behaviour Inventory (Schluderman & Schluderman, 1970, 1983), the Parent-Adolescent Relationship Questionnaire (Robin, Koepke, & Moye, 1990), the Parent Practices Scale (Strayhorn & Weidman, 1988), the Parenting Risk Scale (Mrazek, Mrazek, & Klinnert, 1995), and the Weinberger Parenting Inventory (Feldman & Weinberger, 1994). Observation of the dynamics between a youth and his or her parents during the assessment interview may also provide useful insights about family functioning and relationships.

Assessment of Cognitive and Educational Functioning. Academic underachievement, learning problems, and low intelligence have been associated with antisocial behaviour (Frick, 1998). An assessment of intellectual functioning can provide useful information regarding a youth's cognitive strengths and weaknesses, which has implications for intervention planning and responsivity issues. For example, the selection of intervention strategies for a youth who is academically underachieving because of a learning disability will be different from those selected for a youth that is underachieving because of behavioural reasons (e.g., truancy) despite a capacity to be successful in school. The Wechsler scales are the most commonly used and extensively researched measures of intellectual functioning. The Wechsler Intelligence Scale for Children (WISC-III) is appropriate for use with 6-16 year old, while the Wechsler Adult Intelligence Scale-III (WAIS-III) can be used for older adolescents and adults.

In addition to reviewing the youth's school record to gauge academic performance and behaviour in the school setting, some measures have been developed to objectively measure a youth's academic achievement relative to age appropriate norms. The Wide Range Achievement Test-third revision (WRAT-3) and the Kaufman Test of Educational Achievement (K-TEA; Kaufman & Kaufman, 1985) are two of the more commonly used standardized measures. Both instruments can provide an indication of whether the youth's performance is above, below, or consistent with what would be expected from youths of a similar age.

Assessment of Substance Abuse Problems. Another strong predictor of antisocial behaviour is the misuse of substances (e.g., Lipsey & Derzon, 1998). Youths that abuse substances may commit antisocial acts in order to acquire money to purchase drugs. In addition, the risk of criminal behaviour and violence is increased during intoxication because of its interference with decision-making and problem solving abilities.

Hoge and Andrews (1996) have recommended the use of standardized instruments that are designed to evaluate aspects of substance misuse (type, severity, and frequency of use). Such instruments include the Adolescent Drinking Index (Research Psychologists Press/Sigma), Drug Abuse Screening Test (Skinner & Sheu, 1982), Drug Use Screening Inventory (Tarter, 1990), and the Personal Experiences Screening Questionnaire (Winters, 1991). The use of self-report measures should be supplemented by interview and collateral reports.

Assessment of Interpersonal/Social Functioning. Evaluation of a youth's social functioning and peer group is an important component of assessment involving conduct problem behaviour. During normal adolescent development, the role of peers becomes more pronounced as youths become more involved with their peer groups and less involved with their parents. One of the more robust predictors of antisocial behaviour in later adolescence and adulthood is the association with antisocial peers during adolescence (Lipsey & Derzon, 1998; Simourd & Andrews, 1994; Stouthamer-Loeber & Loeber, 1988). Hence, assessors should inquire about the

nature of a youth's peer group and the activities they involve themselves in (i.e., prosocial versus antisocial activities). In addition, it is useful to obtain an understanding of the youth's general interpersonal functioning (e.g., dating behaviour, quality of close friendships; Munger, 2000).

Information on social functioning and peers influences can be informally determined through interviews with the youth's parents, teachers, or other individuals involved in the youth's life. However, some standardized measures also provide a means of gathering information about the youth's social competencies. These include, the Child Behavior Checklist (Achenbach, 1991) and the Social Skills Rating System (Gresham & Elliot, 1990).

Assessment of Emotional and Behavioural Problems. Longitudinal research indicates that one of the strongest predictors of later antisocial behaviour and violence is a history of conduct problem behaviour and aggression in early childhood and early adolescence (e.g., Lipsey & Derzon, 1998; Hawkins et al., 1998). In addition, ADHD and substance abuse are often comorbid conditions of conduct disorder (American Academy of Child & Adolescent Psychiatry, 1997). Hence, an evaluation of a youth's current and early externalizing behaviour problems is important. Internalizing problems (e.g., anxiety and depression) are not usually directly linked to general antisocial behaviour (Hawkins et al., 1998), but are common among antisocial and conduct-disordered youth (e.g., American Academy of Child & Adolescent Psychiatry, 1997; McManus, Alessi, Grapentine, & Brickman, 1984; Santor & Kusumakar, 1998). As such, emotional problems should be evaluated as they may impact on treatment responsivity and long-term outcome (Hinshaw & Zupan, 1997). In addition, the evaluation of certain mental health symptoms and their severity (e.g., psychotic and anxiety symptoms) may be more relevant to understanding violent behaviour in adolescents (e.g., Santor, Kusumakar, & Porter, 2001; Shumaker & Prinz, 2000). Thus, the nature of any emotional and behavioural problems should be carefully evaluated.

A number of behavioural rating or checklist instruments have been developed for the purpose of evaluating aspects of the youth's social, emotional, and behavioural competencies. Typically, these instruments are administered to the youth's parents/caregivers, teachers, and sometimes to the youth themselves. One of the most widely used measures is the 113-item Child Behaviour Checklist (CBCL; Achenbach, 1991a). In addition to providing a general index of problem behaviour, the sub-scales of this parental report measure provides an index of problems with social functioning, somatic complaints, anxiety, depression, thought disorder, attention problems, delinquency, and aggressive behaviour for 4- 16 year olds. This instrument has teacher and youth self-report counterparts and a standardized observational schedule that collectively yield a multi-source, broad-based perspective on the youth's functioning. There is substantial research in support of the Child Behaviour Checklist and its counterparts (Achenbach, 1991a, 1991b). Another promising broad-based instrument is the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1994). This newly developed tool is designed to measure emotional, behavioural, mental health, and substance abuse problems. Recent studies indicate that the CAFAS is predictive of contact with law and poor school attendance over a 6 month period in

clinic-referred youth (Hodges & Kim, 2000). A higher score on this measure has also been positively associated with recidivism in adolescent offenders (Quist & Matshazi, 2000).

In interpreting behaviour rating measures however, Hinshaw and Zupan (1997) suggest that assessors be sensitive to the fact that the responses reflect the *perspective* of the respondent, which may be biased to some degree. For example, young offenders tend to report the severity of their internalizing and externalizing problems as less serious than their maternal caregivers, while non-delinquent youth report a higher levels of externalizing problems then their maternal caregivers (Butler, MacKay, & Dickens, 1995). Teacher and parental reports are more likely to be consistent with each other then with the youth's self-report of their problem behaviour (Forehand, Frame, Wierson, Armistead, & Kempton, 1991). Hence, the use of multiple informants and evaluation of other sources of information is essential to obtain a balanced impression of the youth's emotional and behavioural problems.

Assessment of Antisocial Behaviour, Attitudes, Values, and Beliefs. Official reports may underestimate the youth's antisocial behaviour because many antisocial acts go undetected (Hinshaw & Zupan, 1997). As such, a youth's self-report may provide a more realistic picture of their antisocial behaviour. Several instruments have been developed to specifically measure a youth's report of antisocial behaviour and the beliefs and values that may support such behaviour. For example, the Self-Reported Delinquency Scale (Mak, 1993) inquires about a wide range of antisocial activities (minor and serious) that the youth may have committed. The Self-Report Delinquency questionnaire (SRD; Elliott, Huizinga, & Menard, 1989) is also a useful means of obtaining information about the frequency of antisocial behaviour in 11-17 year olds. Evaluation of sexually deviant behaviour should involve a more specialized assessment protocol.

Only a few instruments have been specifically designed to tap the antisocial attitudes, values and beliefs that may play role in the maintenance of antisocial behaviour. The Modified Criminal Sentiments Scale (M-CSC; Simourd, 1997) is designed to assesses the respondents attitudes towards the legal professionals (e.g., police and courts), their tolerance of breaking the law, and the extent to which they identify with antisocial individuals. This measure can be administered with the Pride in Delinquency Scale (Shields & Whitehall, 1991) to evaluate the individual's attitudes towards various antisocial activities. Currently, researchers are in the process of testing the properties and utility of an adolescent version of the M-CSC, referred to as the Beliefs and Attitudes Scale (Butler & Leschied, 2001) with promising preliminary results.

Assessment of Personality and Mental Health Concerns. According to Hoge and Andrews (1996), measures of a youth's personality functioning can provide useful information about his or her needs, responsivity concerns, and amiability to treatment. An evaluation of personality dynamics and psychological functioning can also help to identify any mitigating and aggravating factors that influence a youth's antisocial behaviour (e.g., impulse control problems, self-concept, aggressive tendencies; Hoge, 1999). In addition, certain personality disorder symptoms (paranoid,

narcissistic, passive-aggressive) have been associated with a greater risk of committing violent and non-violent criminal acts in both males and females during adolescence and early adulthood (e.g., Johnson et al., 2000).

A number of personality assessment measures have been studied in terms of their utility with adolescents, and more specifically, with antisocial youth. Two of the most commonly used measures of personality functioning and mental health problems for adolescents are the Millon Adolescent Clinical Inventory (MACI; Millon, 1993) and the Minnesota Multiphasic Personality Inventory for Adolescents (MMPI-A; Butcher et al., 1992). Other instruments often used are the Jesness Inventory (Jesness, 1992; Jesness & Wedge, 1984, 1985) and the Basic Personality Inventory (Jackson, 1995). These measures are based on the youth's self-report and can be administered either in a pencil and paper format or through computerized administration programs. Weaver and Wootton (1992) found that some of the scales on the MMPI discriminated persistent from less persistent antisocial adolescents. Variations were also observed for high and low property offenders, serious offenders, and violent offenders. Like the MMPI, the MACI has been used with antisocial adolescents and some scales have been associated with aspects of violent behaviour, such as instrumentality and empathy/guilt issues (e.g., Loper, Hoffschmidt, & Ash, 2001). There is only limited research in support of the predictive validity of the classification system of the Jesness. The psychometric properties and utility of the Basic Personality Inventory have been supported with antisocial youth (Jackson, 1995; Jaffe, Leschied, Sas, Austin, & Smiley, 1985).

Assessment of Community/Neighbourhood Factors. Although not directly related to antisocial behaviour, systemic and social-ecological models of antisocial behaviour clearly speak to the indirect influence of the youth's community on the risk of antisocial behaviour. Communities that are dominated by a high level of poverty/low socio-economic status, disorganization, criminal activity, violence, and easy access to drugs may increase the youth's risk of antisocial behaviour (e.g., Hinshaw & Zupan, 1997). Clearly, not all youths from such communities will develop antisocial behaviour, especially in the presence of protective factors (e.g., positive family functioning, prosocial peers). However, clinicians should be aware of the increased risk represented by negative community influences, particularly when the youth may be returning to that environment. On the other hand, an evaluation of the community's strengths and resources may assist in case planning if the youth is able to take advantage of them. Information on the nature of the community and its resources can be obtained during interviews with the youth and his or family and from the assessor's general understanding of the community.

Actuarial Risk/Need Assessment Instruments. The estimate of risk is important because it guides decisions regarding the nature, timing, and intensity of intervention strategies to best reduce the risk. It is clear however, that without the use of validated risk assessment measures and protocols, most professionals are only at chance accuracy in making such predictions (for reviews see Andrews, 1989; Heilburn, 1997; Litwack & Schlesinger, 1999; Monahan, 1996;

Monahan & Steadman, 1994; Rice, 1997). One reason that the use of validated risk tools increases the accuracy of our predictions is because these instruments are based on the static and/or dynamic risk factors that have been identified in the literature as predictive of criminal behaviour. These instruments have substantially improved the ability to estimate the risk of violence and recidivism in adults (see (Bonta, Law, & Hanson, 1998; Borum, 1996; Dawes, Faust, & Meehl, 1989; Grove & Meehl, 1996; Lidz, Mulvey, & Gardner, 1993; Mosson, 1994; Quinsey, 1995; Skeen, Mulvey, & Lidz, 2000). However, compared to what is available for antisocial adults, there are comparatively few risk assessment tools for antisocial youth.

Two actuarial measures (described below) represent recent and promising Canadian efforts in the development of risk assessment protocols for antisocial youths.

1. Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 1994. The YLS/CMI is an empirically supported, broad-based risk/need assessment instrument developed in Ontario. This measure is completed by a trained professional after the gathering of information from interviews with the youth and collateral contacts, review of assessment results and file information, and observational data. Once completed, the inventory provides a total risk score and identifies need areas that may benefit from intervention to reduce risk. The YLS/CMI has adequate psychometric properties and assists in the identification of youths at risk and with various need levels (e.g., Simourd, Hoge, Andrews, Leschied, 1994). Although its false positive rate is somewhat high (36%) the YLS/CMI has discriminated general recidivists from non-recidivistic young offenders (Jung & Rawana, 1999).

2. Psychopathy Checklist-Youth Version (PCL-YV; Forth, Kosson & Hare, in press). The PCL-YV is an adolescent version of the Psychopathy Checklist-Revised (PCL-R; Hare, 1991). Both the PCL-R and PCL-YV are designed to measure psychopathic personality traits and antisocial behaviour/lifestyle characteristics. The 18-item PCL-YV is completed by a trained professional following a semi-structured interview with the youth and an extensive review of the case file information and collateral contacts. Although the PCL-R uses a clinicul cut-off to diagnose psychopathy in adults, such criteria has not been clearly defined for the PCL-YV. However, the dimensional nature of the PCL-YV can provide useful information about the nature and severity of antisocial and psychopathic traits and its psychometric properties are generally good (e.g., Brandt et al., 1997; Forth et al., 1990). The severity of psychopathic traits, as measured by the PCL-YV, can provide useful information regarding the nature of a youth's antisocial orientation and their risk of future violent behaviour. As such, the PCL-YV is useful as a component of protocols for the assessment of antisocial behaviour. However, given the developmental changes that occur during adolescence and the lack of prospective longitudinal research on psychopathy from childhood to adulthood, Edens, Skeem, Cruise, and Cauffman (2001) do not recommend the use of the PCL-YV in decisions pertaining to the long-term placement of youths.

Special Considerations in the Assessment of Youth with Antisocial Behaviour

Developmental Issues. Halikias (2000) indicated that an awareness of the typical developmental pathway of antisocial behaviour is important for clinicians conducting evaluations with antisocial youth. It appears that some degree of antisocial behaviour is to be expected as part of normal adolescent development (Moffitt, 1993). Only about 5% of antisocial youths develop their antisocial behaviour in childhood and maintain such behavior into adulthood (i.e., "life-course persistent"; Moffitt, 1993; Moffitt et al., 1996). It is this smaller group of youths that are responsible for the majority of crimes (Halikias, 2000; Moffitt, 1993). Thus, when evaluating the long-term risk of future antisocial behaviour, assessors should be aware that most antisocial youths tend to reduce or discontinue such activity once they reach early adulthood.

In addition to changes in the rate of antisocial behaviour with adolescent development, there is some evidence that the influence of certain risk factors may also vary with age. For example, a meta-analysis of longitudinal data (Lipsey & Derzon, 1998) indicated that between the ages of 6 and 11, substance use and early criminal behaviour were the strongest predictors of later serious or violent criminal behaviour at 15-25 years of age. However, during early adolescence (12-14 years old) the strongest predictors of later serious or violent delinquency changed to a lack of social ties and association with delinquent peers. Clinicians should be aware of the developmental changes in the influence of risk factors when evaluating antisocial youth and may vary the weight given certain factors depending on the youth's age and developmental level.

Protective Factors. A number of experts (e.g., Hinshaw & Zupan, 1997; Rogers, 2000) have argued for increased attention to the strengths within the youth and his or her environment during assessments. In the past, there has been a tendency for clinicians to over focus on deficits, weaknesses, and risk factors. Identified strengths can provide useful information about *protective or resiliency factors*. In general, protective factors have been found to mediate the risk of antisocial behaviour via their interaction with the risk factors for this behaviour (American Academy of Child and Adolescent Psychiatry, 1997). In support of this argument, Hoge, Andrews, and Leschied (1996) have identified four protective factors against new criminal convictions. These are pro-social peer relationships, good educational achievement, positive response to authority, and effective use of leisure time. The positive influence of these protective factors occurred regardless of the youth's risk level (high or low). In addition, the positive effects of protective factors was stronger among older (15-17 years old) than younger adolescents (12-15 years old). Other identified protective factors have included a high IQ, an easy temperament, areas of competence outside of school, and a positive relationship with at least one parent or significant adult (American Academy of Child & Adolescent Psychiatry, 1997). Hence, an important component of the assessment of conduct problem youth is the consideration of protective factors to provide a more balanced perspective of the youth and their risk of persistent antisocial behaviour. Professionals may also draw on the strengths to develop effective case management strategies.

Gender. Most of the research on antisocial behaviour in adolescence has been conducted with males. Given the limited attention to females, it is not clear whether male derived risk factors for antisocial behaviour equally apply to females. Existing research on the predictors of female delinquency is ambiguous and limited by methodological difficulties (Hoyt & Scherer, 1998). Some studies have supported the possibility that there are gender specific risk factors for delinquency. However, the origin of gender differences in antisocial behaviour is unclear and proposed explanations have generally not been well accepted (e.g., the rise in feminism, Power-Control Theory; Hoyt & Scherer, 1998). Additional empirical research is required to better understand possible similarities and differences in the predictors of antisocial behaviour in female and male adult and young offenders. Clinicians should be aware of this limitation when assessing females with conduct problem behaviour.

Conclusion

A review of the literature suggests that the most efficient means of assessing antisocial youth is to use a comprehensive and structured protocol that includes the administration of standardized assessment instruments shown to provide useful information about risk/need factors for antisocial behaviour. Such a comprehensive and empirically-based assessment protocol can assist professionals in understanding the dynamics of a youth's antisocial behaviour (e.g., mitigating and aggravating factors, risk factors), estimating the risk of future antisocial behaviour, and the selection of intervention strategies based on the youth's identified needs and responsivity concerns. As recommended by Hoge and Andrews (1996), the implementation of a standard set of assessment instruments across a system can be beneficial as it helps to ensure consistency in that system in terms of assessment practices and decisions based on those practices. The selection of the assessment battery should be driven by the type of information required to make the decisions for which the assessment is required (e.g., risk/need evaluation), use of multiple sources of information (e.g., parent, youth, teacher), and use of a variety of assessment formats (e.g., interviews, checklists, self-report).

SECTION 5: BEST PRACTICE INTERVENTION PROGRAMS

Issues in Residential Placement

In the United States, initiatives around deinstitutionalization began with the introduction of the Juvenile Justice and Prevention Act of 1974. This Act marked the beginning of a major federal effort to limit the incarceration of juvenile offenders in jails, detention centers, correctional facilities and other institutional settings. In a search for alternatives to incarceration, residential treatment centers and foster homes became popular choices for juvenile offenders whose home environments were unsafe or inappropriate. During the 1960s and 1970s group home treatment programs grew in popularity as a form of residential treatment for adolescents who had experienced behavioural problems and needed more intensive treatment and supervision than could be offered in foster care (Stanton & Meyer, 1998). Youth who are institutionalized have typically failed in less restrictive, community based programs. Out of home placement usually represents a last resort by the court to control, rehabilitate or punish youth (Gordon et al., 1998). Residential or institutional placements can also provide a period of observation and evaluation of the mental health status and behaviour of the youth. As well, placements can occur to provide respite to the family from the turmoil of managing the antisocial youth's behaviour. In addition, committing a violent offense often leads to an automatic consequence of placement out of the home because of the perceived threat to the community if this behaviour continues (Gordon et al., 1998).

One difficulty with institutionalization is that the youth are removed from and can become disconnected from families or substitute caregivers. Jones (1984) noted the importance of maintaining a solid connection between the youth and the parents or parental surrogates. Maintaining connectedness requires the involvement of families during the period of out-of-home placement and in designing and maintaining aftercare programs for the youth. According to Jones, large residential treatment facilities become dumping grounds when they are expected to correct the social problems of young offenders.

The institutionalization of young offenders is an issue which is much debated in the public forum. According to Butts and Barton (1995) most advocates of building and filling more institutions make one of several arguments: (1) that crime is increasing in seriousness and frequency and the solution is to institutionalize potential threats to society, (2) that the fear of living in an institution deters criminal behaviour and (3) that institutionalization prevents criminals from committing more crimes. Butts and Barton (1995) argue that there is no support for the belief that incarceration acts a deterrent for juvenile crime in recidivism studies, and youth tend to commit more crimes once released. These authors also point out that institutions are expensive to build and operate and often serve to bring delinquent peers into contact with other delinquent peers. When behavioural improvements are made during institutional stays, as

a result of good behavioural and cognitive behavioural programming, these improvements are not transferred to the natural environment once the youth is returned to the community.

The efficacy of group homes has been demonstrated for some programs that offer a family type atmosphere where youth and house parents establish familial ties. Steward, Vockell and Ray (1986) followed 906 young offenders over three years and found that the youth in family type group homes had a significant reduction in recidivism. Evaluations of these family-type group homes has shown that they significantly reduce residents' delinquent behaviour and substance use compared to youth in standard group homes, however almost all evaluations found that behavioural improvements disappear once the youths left the placement (Braukmann et al., 1987; Kirigan et al., 1982).

Gordon, Jurkovic, & Arbuthnot (1998) discuss a large review of correctional programs in 1993 which found that large congregate-care correctional facilities had not been proven to be effective. The recommendations from this major review were to: (1) strengthen the family (or family surrogate); (2) support core social institutions such as school, community organizations and churches in socializing youth; (3) promote delinquency prevention; (4) intervene quickly with these youth centering on the family interventions; and (5) identify and control the small group of serious violent, and chronic offenders who do not respond to intervention and community based treatment. This latter group, when they are a threat to community safety, should be placed in secure facilities as a last resort.

Best Practice Standards for Intervention Programs

In evaluating specific models of assessment and intervention with antisocial and conduct disordered youth, a standard of Best Practice was utilized. Best Practice models are identified from published studies of program evaluations, clinical trials, review articles and meta-analyses. Accepted standards for evaluating the effectiveness of programs are identified in the U.S. Surgeon General's Report on Youth Violence (Department of Health and Human Services, 2001) and include:

1. The use of experimental design. A rigorous experimental design includes random assignment to treatment and control groups. A quasi-experimental design uses equivalent treatment and control groups without random assignment.

2. Reasonable rates of attrition. High rates of attrition compromise the comparison between treatment and control groups and suggest some flaw in the program.

3. Use of appropriate measurement tools: It is important to measure the expected outcome of the program with tools that validly and reliably measure what is expected to change.

4. Evidence of change: Statistical analysis must verify significant change which can be attributed to the treatment intervention.

5. Sustainability of change: Effective programs are expected to produce long-term changes in individual skills, environmental conditions and patterns of behaviour. Measurable effects after one year were considered to have met the test of sustainability.

6. Replication of results: The effects found in original studies must have been replicated at multiple sights or in clinical trials.

The principals of Best Practice were key in evaluating and recommending specific intervention techniques from the research literature for inclusion in the present feasibility study.

Characteristics of Successful Community-Based Programs

Based upon a review of the literature Butts and Barton (1995) have identified a number of common characteristics of effective community based interventions for antisocial youth:

(1) Each youth should have an individualized treatment plan. The first step in designing an individualized treatment plan for an adolescent is a thorough assessment.
(2) The treatment plan needs an overseer or case manager who will monitor adherence to the plan, and see that the appropriate needs are being addressed. Successful in-home programs reviewed use some model of case management and case managers must have sufficient flexibility to provide, seek, develop, or broker whatever services are needed.
(3) The program needs to provide case managers with flexible resources and allow them to pursue creative strategies as long as accountability is maintained.
(4) Programs should have a concrete focus.
(5) Programs should have a family and community focus.
(6) Community linkages (using existing community resources, providing support to families, encouraging client-community contact, etc.) are emphasized.
(7) Staffing and supervision are important considerations for effective programming.

In addition to these characteristics of successful programs, it is important, if programs are going to gain community support for implementation, that they be developed as alternatives to out of home placements, as this will be a cost saving measure that will lend credence to proposed service delivery models. The youth served must clearly have been headed for secure detention centers, training schools, or other institutions, that we know are expensive to operate and have limited effect on reducing recidivism. Alternatives to incarceration must be seen as both fiscally responsible, and more responsive to the needs of the population being served. Another important

factor is that in-home staff must have sanctioning mechanisms other than a return to the regular institutional system to deal with youth who violate program rules or are generally uncooperative. If the youth are constantly being remanded back to institutions as consequences for misbehaviour, the effectiveness of community based programming is compromised. Successful in-home programs also have to consider the demand on their case managers. The intensity of involvement, long and irregular hours of work, and role ambiguities all make it difficult for staff to retain necessary levels of energy and commitment. Programs need to support front line staff and provide them with sufficient flexible resources.

Similarly, Borduin & Schaeffer (1998) in a review of treatments for violent criminal offenders conclude that effective treatments for this population should :

(1) be flexible
(2) address the multiple determinants of the behaviour
(3) be intensive and
(4) be ecologically valid.

According to Borduin and Schaeffer (1998) treatment needs to be flexible because the antisocial behaviour of violent youth includes both violent and nonviolent antisocial behaviours. The treatment must address the multiple causes of the behaviour in order to effectively make change, such as the adolescent's cognitions, family relations and peer relations, all of which support the behaviour. The fact that the violent youth is on a long term course toward adult criminality and is difficult to deter from this course, requires that the treatment be intensive and pervasive in the youth's life.

Examples of Successful Community Based Programs

Literature reviews consistently conclude that comprehensive, individualized community based, family oriented interventions appear to hold the most promise and social-cognitive interventions should be encouraged as a critical component of both institutional and community based care (Tate, Reppucci & Mulvey, 1995, Schoenwald, Borduin, & Henggeler, 1998; Stanton & Meyer, 1998; Kazdin, 1998). What works best for violent or seriously delinquent youth are (1) behavioural and skill development interventions which include social perspective taking and role taking components, and (2) family clinical interventions that focus on changing maladaptive or dysfunctional patterns of family interaction and communication, including negative parenting practices (Department of Health and Human Services, 2001). The Surgeon General's Report states that the three model programs that use a family therapy approach are Functional Family Therapy, Multisystemic Therapy and Multidimensional Treatment Foster Care. Two justice system approaches have promise, and they are the Intensive Protective Supervision Project and Wraparound Services.

Justice System Programs. Justice system programs may have a small but significant effect on reducing recidivism. Intensive Probation Supervision, for example, is a popular form of aftercare that provides frequent and intense contact between the probation officer and the youth (Stanton & Meyer, 1998). Intensive aftercare programs provide close monitoring and supervision by probation officers and may offer rehabilitative opportunities to the youth. It is assumed that close surveillance deters criminal commission and rehabilitation prompts behavioural changes. Presumably, deterrence and rehabilitation would produce an actual change in the propensity to commit crime and aftercare effects would be seen in a reduction in re-arrests. The most promising aftercare programs feature small caseloads, frequent contact, and a variety of service and advocacy activities (Butts & Barton, 1995). General support and assistance appears to be of little benefit unless risk factors for delinquency are addressed. ISP requires a reduced caseload, increased frequency of contact with the youth and expanding the surveillance and monitoring role of the officer but this service appears to work best if there is a treatment component that is based upon a risk-needs assessment of the youth and if intervention occurs in multiple settings (Altachuler, 1998).

Wraparound Care is an approach to treating youth that commits to providing an individualized plan of care for the youth, one that arranges services in the community for the youth and does not try to fit the youth into already existing programs that may or may not be useful. In this approach a multi-disciplinary team, including the youth and the parents and appropriate service providers develop a service plan that addresses both the short and long term needs of the youth and services are chosen that will best meet these needs. There are only a few controlled outcome studies available. One study showed reductions in recidivism and arrests one year after participation in the program (Department of Health and Human Services, 2001).

Treatment Programs. Programs that meet the criteria for best service are Cognitive Behaviour Skills Training programs, Parent Management Training, Functional Family Therapy, Multi-dimensional Treatment Foster Care, and Multisystemic Therapy. The latter two interventions are multi-modal interventions.

Cognitive Behavioural Skills Training include social skills training, anger management and problem solving skills training. These approaches assume that antisocial behaviour in adolescents stems from a lack of cognitive and interpersonal skills for managing relationships with peers, family and school. They utilize methods such as modeling and behavioural rehearsal to teach adolescents improved problem solving, moral reasoning, anger control and interpersonal relationship skills. One difficulty with these skills training programs is that, if delivered in institutions, they tend not to have sustainability after release from the institution in decreasing aggressive, violent offenses. These programs do tend to have short term effects. In addition, the most effective programs are those that combine a strong ecological approach with cognitive behavioural training, individualized contracts, and family therapy (Stanton & Meyer, 1998). *Problem Solving Skills Training (PSST)* is an example of a cognitive behavioural technique that

has some success. Treatment is aimed at the development of self control, social responsivity, and developing interpersonal cognitive problem solving skills. Children are taught to engage in step by step approach to solve interpersonal problems. They make self statements that direct their attention to specific aspects of the problem or task that will lead to effective solutions. Prosocial behaviors are fostered through modeling and direct reinforcement as part of the problem solving process. Cognitively based treatments have significantly reduced aggressive and antisocial behaviour at home, at school, and in the community (Kazdin, 1997). Kazdin (1996) compared the PSST program with the Parent Management Therapy (PMT) program and found that the combined treatment effects had the best outcome for youth maintained at one year follow-up.

Parent management training (PMT) (also known as Behavioural Parent Training - BPT) is an attempt to train parents to use specific procedures to alter interactions with their children in order to promote prosocial behaviour and decrease deviant behaviour. This approach assumes that conduct problems are being developed and sustained in the home by maladaptive parent-child interactions. The pattern of maladaptive interactions may include directly reinforcing deviant behaviour, frequently and ineffectively using commands and harsh punishments, or failing to attend to appropriate behaviour. The effects of PMT are well known with younger children (see Borduin et al., 1998). PMT has an impact not only on the targeted child, but on the siblings, and it has a larger effect and more durable effect if the period of intervention is over 50 to 60 hours or is time-unlimited (Altepeter & Korger, 1999). Specific training components enhance treatment effects (e.g., time-out procedures) and the level of training of the therapist has an effect on treatment outcome, but families with multiple risk factors tend to have fewer gains and maintain gains less well than lower risk families (Altepeter & Korger, 1999). PMT appears to have the most utility as a secondary preventative intervention, i.e., as an intervention for younger behavioural problem children who are at risk of becoming juvenile offenders. However, all multidimensional interventions and family interventions that work with young offenders include a parental behavioural management component.

Functional Family Therapy (FFT) is a form of family therapy aimed at conduct disordered youth. FFT targets youth between the ages of 11 and 18 who are at risk of or already demonstrating delinquency, violence, substance use, conduct disorder, oppositional defiant disorder or disruptive behaviour disorder. FFT is a multistep, phasic intervention that includes 8 to 30 hours of direct services to youths and their families, depending upon individual needs. FFT integrates treatment strategies from systems theory with behaviour therapy and has been regarded as one of the most promising treatments of antisocial behaviour in adolescents (Kazdin, 1998). Within FFT it is assumed that the families of conduct disordered youth need to alter their problematic communication patterns and improve supervision and discipline within the family. Families of conduct disordered youth have a greater level of defensive communication and lower levels of supportive communication compared to families of non delinquent youth, and they also have lower levels of supervision. Facilitation of communication skills, problem solving skills and negotiation skills are components of FFT. There is extensive use of relabelling and reframing to

reduce blaming and to help parents move from seeing the youth as inherently deviant to someone whose deviant behaviour is maintained by situational factors (Brosnan & Carr, 2000).

Studies that compare the effects of Functional Family Therapy to probation-only control groups show a dramatic decrease in the recidivism rates of youth treated with the FFT model (e.g., 9% verus 41 % in Gordon, Graves, & Arbuthnot, 1995; and 11% versus 67% in Gordon, Arbuthnot, Gustafson, and McGreen, 1988). In another study of serious multiple offenders treated with FFT upon release from institutions, Barton, Alexander, Waldron, Turner, and Warburton (1985) report that at 15 month follow-up, the treated group had a recidivism rate of 60% verus 93% recidivism for those youth placed in group home placements following release. Kazdin (1997) in a review of the literature concluded that the controlled studies of FFT indicated greater change (improved family communication and interactions and lower rates of referral to and contact of youth with courts), than other treatment conditions (such as family groups and psychodynamically oriented family therapy) and control conditions. These gains have been evident in separate studies up to 2 ½ years after treatment (Kazdin, 1997). The benefits of FFT include the effective treatment of conduct disorder, ODD, disruptive behaviour disorder, and alcohol and other drug use disorders, reductions in the need for more restrictive costly services and other social services, reductions in incidence of the original problem and reductions in the proportion of youth who eventually enter the adult criminal justice system. Evidence of secondary benefits to siblings also was found (Department of Health and Human Services, 2001).

Multimodal Programs. A variety of multi-modal programs have been used with young offenders. One such program is *Family Ties*. The Family Ties program is a family preservation program that targets offenders who are at imminent risk of out-of-home placement. The program is an individualized ecological intervention that is intensive, flexible, time limited and goal oriented. A family preservationist is assigned to the family and works with them for 10 to 15 hours a week over 4 to 6 weeks. Each family preservationist has a caseload of two families and is expected to provide coverage 24 hours a day 7 days a week. Treatment is provided in the home, school and neighbourhood settings, and includes individual and family counseling. At the end of treatment a judge evaluates the progress of the youth and family and decides if the youth should be placed on probation or in a youth facility. While there are no randomized clinical trials available, studies report up to 70% of the graduates of this program avoided subsequent institutionalization (Borduin, Heiblum, Jones, & Grabe, 1998). The effect of the Family Ties program appears to be greatest in the first three to six months after the service.

Multisystemic Therapy (MST) has received the most empirical support as an effective treatment for serious and violent offenders. It is intensive, time limited, home based and ecologically sound. MST interventions are consistent with findings from causal models of violent juvenile offending and address a broad range of factors contributing to the identified problems (Borduin and Schaeffer, 1998). MST utilizes treatment strategies that include aspects of strategic family therapy, structural family therapy, behavioural parent training, and cognitive behavioural therapy.

MST interventions are individualized and highly flexible. There are 9 treatment principles that are the basis of MST interventions. MST is usually delivered by a master's level therapist with a case load of 4 to 8 families (Borduin, Heiblum, Jones and Grabe, 1998). The MST therapist is a generalist who provides most mental health services and coordinates access to other important services. The therapist is available to the family 24 hours a day 7 days a week, but the intensity of the direct service is based upon need. Intensive training and supervision of therapists is important to MST outcomes. Treatment fidelity is maintained by weekly group supervision meetings of a team of 3 to 4 therapists and a doctoral level clinical supervisor. Rigorous outcome evaluation studies have been completed on MST. MST had significant effects on many outcome measures included the number of re-arrests, self reported delinquency, and time incarcerated, (Henggeler, Melton, and Smith 1992), as well as decreased reports of behavioural problems, decreased association with deviant peers and improved family functioning. This treatment program has also been shown to reduce recidivism for drug related crimes (Henggeler et al., 1993). Borduin et al (1995) demonstrated the relative effectiveness of MST in reductions in criminal and violent reoffending at 4 year follow-up.

In *Multidimensional Treatment Foster Care*, the goal is to modify conduct problem maintaining factors within the child, family, school, peer group, and other systems by placing the child temporarily within a foster family in which the foster parents have been trained to use behavioural strategies to modify the youngster's deviant behaviour (Chamberlain, 1994). Treatment foster parents are carefully selected and trained in the principles of behavioural parent training. The youth receives the MST-type treatment programming in the home, school, peer group and community. The natural parents also receive behavioural parent training in order to maintain the youth when they come home. The goal is to prevent long term separation of the family. Multidimensional Treatment Foster Care targets teenagers with histories of chronic and severe criminal behaviour as an alternative to incarceration, group or residential treatment, or hospitalization. This program recruits, trains and supervises foster families to offer youth treatment and intensive supervision at home, in school, and in the community. The program provides parent training and other services to the biological families of treated youth helping to improve family relationships and reduce delinquency when the youth returns home. Youth receive behaviour management and skill focused therapy and a community liaison who coordinates contacts among case managers and others involved with the youth. Evaluations have indicated that this program can reduce the number of days of incarceration, overall arrest rates, drug use, and program dropout rates in treated youth versus controls during the first 12 months after completing treatment (Chamberlain & Reid, 1998).

A fairly new intervention in the research literature is *Prosocial Family Therapy*. This is also a multimodal intervention that uses a systemic model and an ecological approach (Blechman and Vryan, 2000). Prosocial Family Therapy (PFT) is designed to substitute prosocial coping for self-centered coping. PFT is a manualized approach to intervention. The use of a manualized approach increases treatment fidelity and adherence to the model by the therapists, decreases the

need for seasoned and mature therapists, and lends some assurance to the fact that the therapists are providing a treatment that has measurable effects. In order to check adherence to the model, the therapist completes an in-session checklist, and at times, a trained observer checks adherence either through videotape or through direct observation of the session. The Assessment Staff administer a standardized battery of tests to the youth, parents, and teachers and collect corroborating information from official records at repeated intervals. The treatment phase is relatively brief, 12 to 15 weekly, 50 minute sessions. Data is not yet available on the treatment effects of this intervention but it does sound promising as it is based upon the principles of other programs that are effective. The intervention has a well defined evaluation component with a multiple baseline design, however it does not have randomized assignment to treatment modalities, such as MST has undertaken.

Interventions Shown to be Ineffective

The following forms of intervention have been proven ineffective in empirical studies according to the US Surgeon General's Report (Department of Health and Human Services, 2001) : Boot Camps, residential programs in correctional or psychiatric settings, milieu therapy, token programs, transfers to adult court, individual counseling, shock programs and wilderness retreats. Boot Camps are modeled after military basic training with a primary focus on discipline. Mackenzie and Souryal (1994) concluded that boot camp programs do not reduce recidivism. When compared to traditional forms of incarceration, boot camps produced no significant positive effect and increased recidivism. Boot camps focus very narrowly on physical discipline and do not address a broader range of skills and competencies.

Residential programs that occur in psychiatric or correctional institutions show little promise of reducing subsequent crime and violence in delinquent youth. Research demonstrates consistently that any positive effects of residential care diminish once the youth leave the facility. Evaluations of two residential programs showed that youth were actually more likely to be rearrested and more likely to report they had committed serious offenses (Department of Health and Human Services, 2001).

Milieu treatment occurs in institutions when residents are involved in day to day decision making and therapeutic discussion. There is no empirical support for this approach. Behavioural token programs also operate within institutions and provide the youth with points or tokens for conforming to rules, exhibiting prosocial behaviour and not exhibiting antisocial behaviour. These programs can have positive effects within the program but do not generalize to the natural environment. Long term follow-up on youth who were transferred to adult court has found an increase in youth criminal behaviour (Department of Health and Human Services, 2001), perhaps because those youth who were placed in adult detention centers learned more deviant behaviour in those settings. Individual counseling has been shown to have no effect on recidivism. Scared

Straight is an example of a shock probation program in which brief encounters with inmates describing the brutality of prison life is expected to shock or deter youth from committing crimes. Numerous studies have shown that this program does not deter future criminal activities.

There are a number of peer-based interventions that have been studied with little support for their effectiveness (Borduin & Schaeffer, 1998; Dishon & McCord, 1999). Borduin and Schaeffer (1998) state that treating delinquents in groups can exacerbate their problems, although there is some evidence of the benefits of placing these peers in groups with prosocial peers. Wilderness therapies feature experiential learning, high arousal, and physical and emotional stresses thought to challenge the maladaptive social behaviours of problem youth and their families in a context that requires working cooperatively within a society that encourages the development of trust, effective communication and problem solving skills. The bulk of research on wilderness therapy suggests that such programs change attitudes and self-perceptions more so than behaviours. More effects are found if the treatment involves families. Adventure programming with families is a variant of wilderness therapy. Adventure programming temporarily removes the family from the context of their lives. This approach has shown only small effects of treatment (Schoenwald, Scherer, & Brondino, 1997).

Conclusions

Butts and Barton (1995) state that the most effective programs seem to rely on a multimodal approach that combines behavioural supervision with a focus on skill development, family support and involvement, attitudinal and motivational change, advocacy, and service brokerage in the community delivered by a motivated staff with good relationship skills. This flexible, individualized package can be provided in community-based residential settings or in nonresidential programs. The evidence shows that such programs can be cost-effective alternatives to incarceration for even relatively serious delinquent youth. MST is an intervention that meets this standard for effective programs. Stanton and Meyer (1998) in a review of treatment approaches to juvenile offenders, concluded that MST is the only treatment program to date that has demonstrated short- and long term efficacy with chronic, serious, and violent juvenile offenders in well-controlled studies. Schoenwald, Borduin, and Henggeler (1998) state that MST probably works well because it has a focus on the comprehensive array of factors contributing to the etiology of serious antisocial behaviour, has ecological validity in that it occurs within the settings where the behaviours occur, relies on problem focused present focused and active intervention techniques that have some empirically demonstrated validity, provides training, monitoring and supervision of MST implementation by trained therapists and devotes considerable energy to the development and maintenance of positive inter-agency collaborations.

SECTION 6: THEORETICAL BASIS FOR THE PROPOSED MODEL OF SERVICE PROVISION

Interventions that operate from a theoretical model have shown more promise in meeting their program goals since they have a theoretical rationale that can explain both the etiology of the dysfunction (i.e., conduct disorder) and how treatment can address the disorder (Kazdin, 1997). This is true for the programs and interventions described in this study as having demonstrated efficacy. For example, the Response Program in British Columbia operates from an attachment model, while Multisystemic Therapy is derived from a social ecological model. There are numerous theoretical models which have attempted to describe and explain anti-social behaviour. What follows is a description of several of these theoretical models and an attempt to integrate them into a proposed service delivery model for antisocial and conduct disordered youth in Nova Scotia.

Attachment Theory. Attachment theory (Bowlby,1969/1982; Ainsworth et al., 1978) proposes that early and ongoing experiences within the child-caregiver relationship are reflected in the development of the individual's "internal working model" of relationships. These internal working models are the basis of the adolescent's belief system. When children experience aversive parenting, they develop a working model or belief system about adults as being unwilling or unable to provide nurturance, emotional support and/or needed security. The internal representation of the adult caregiver as a benevolent, responsive, trustworthy and dependable being, assists children of all temperaments in establishing self regulatory behaviours. Through identification with a soothing caregiver, the infant learns to regulate his or affect downward and re-establish a sense of calm after a period of distress. Children who do not have positive internal representations of adult caregivers due to a history of neglect of their needs, lack of consistency in caregiving, or abusive interactions with adults, are likely to turn away from adults and develop negative beliefs about adult's abilities to be caring or helpful or trustworthy. As they grow older, these youth tend to gravitate toward their peers to satisfy their need for acceptance and positive regard. They also tend to develop a sense of themselves as unworthy of care and as possessing negative qualities that lead others to reject them. Their actions, which become aggressive and destructive, then tend to reinforce their beliefs, as adult authority figures react to the youth's negative and aggressive behaviour in a controlling and aggressive manner. The belief system of the child/youth then takes on a self-perpetuating quality.

Social Process Model. The Social Process Model of adolescent deviance (Erickson, Crosnoe, & Dornbusch, 2000) assumes that the motivation for deviance is a desire for the immediate gratification of unfulfilled needs. This model assumes that people learn deviant behaviour and the motives, attitudes and techniques that support deviance, within intimate relationships. The probability of engaging in deviant behaviour is determined by the ratio of pro-deviant to anti-

deviant role models. The Social Process Model assumes that people actively choose to engage in deviant behaviour or to follow societal rules, and the decision which is made is based upon the strength of the individual's established *"social bonds"* to conventional institutions and beliefs. People with weak social bonds are more likely to engage in law violation, however, when social bonds are strong, unlawful behaviour threatens personal relationships, commitments, and accomplishments. Social bonds are the hooks that connect the person to social conventions. Social bonds have four elements, attachment, commitment, involvement and belief. Attachment refers to an individual's affective ties to significant others, such as parents, peers or teachers. Individuals with strong attachments are sensitive to the opinions and feelings of people they value. The anticipation that deviant behaviour will disappoint a significant other or disrupt a social relationship controls the impulse to break the rules. Commitment refers to investments in conventional activities and goals, such as those relating to education and future employment. The greater the investments the lower the likelihood that an individual will jeopardize personal accomplishments and future opportunities with illegal conduct. Involvement reflects the time and energy spent participating in conventional activities. High levels of involvement decrease the amount of time available for non-conventional activities. Belief refers to the degree to which an individual accepts and abides by societal rules and values. The Social Process Model suggests that there are 5 social bond elements: parental attachment, parental supervision, teacher attachment, educational commitment and community involvement. Schools and communities provide settings outside of the family where youth can develop connections with caring adults and commitments to societal values.

Systems Theory. Systems theory (Minuchin, 1974; 1985) suggests that the causal influences that shape human behaviour are multifaceted and interactive. Systems theory assumes that behaviour or misbehaviour occurs within a context of simultaneously occurring, mutually influential, and interrelated factors. Within a systemic model, the whole is considered to be more than the sum of its parts. In this paradigm behaviour is determined not only by factors A and B and C in a linear causal fashion, but also by the interactions between A <> B, B <> C, C <> A, and the three way interaction of A <> B <> C. In systems theory, behaviour is viewed as a function of dynamic interactions of elements of the whole system and the systems's transactions with larger systems. Any particular behaviour is seen as having multiple causes.

Social Ecological Theory. The theoretical underpinnings of Social Ecological Theory (Brofenbrenner, 1979) are somewhat more encompassing and more general than systems theory. Brofenbrenner theorized about more than just close interpersonal relationships, he theorized about the nature of human development within environmental contexts. Like systems theory, social ecological theory proposes that we are growing entities that actively restructure our environments while being influenced by those environments. Mutual accommodation of individuals and ecologies occurs as a result of the reciprocal influence between the two. However, social ecological theory takes an even broader perspective on the influences on human development.

This theoretical perspective considers the impact of the larger society, factors such as social policy, economic hardships, school policy making, and violence in the media.

Dynamic Systemic Model

Figure 6.1 illustrates the model used as a guide in understanding the underpinnings of disruptive behaviour in youth. It is not meant to illustrate any of the specific models described above. Rather, this model assumes that each of the theoretical models described contributes key elements to an understanding of the complex phenomenon of anti-social behaviour.

Attachment theory helps us understand some of the characteristics which are inherent to the youth at risk. Problems with attachment in antisocial and conduct disordered youth are prominent. Disconnected and adult-alienated youth do not respond to social controls imposed by adults because they are not socially bonded to social values, to social control agents in the family or in the school, and because they are not connected or bonded to a prosocial system of educational achievement and community involvement. The youth brings other inherent characteristics (e.g., coping skills, competencies, deficits, mental health problems, learning abilities and temperamental characteristics) into a system.

Systemic theory offers a model of understanding the mutually dynamic ways in which systems impact on one another. Many of the factors inherent to the youth have been shaped by family and environmental influences. As well, the members of a family have histories of interaction with each other that may be positive or negative. The family has a set of operating principles for the maintenance of the family unit. There are specific parenting practices, marital relationships, and individual personal histories, competencies and problems solving skills that characterize members of families. Parents have individual competencies that help them to promote and foster attachment feelings within their children. The environment has good or bad schools, high crime or low crime rates, better or worse programs for youth after school, cultural experience opportunities or not, good or bad teachers, responsible social service agencies or not, police presence or not. At one point or another each of these factors impacts on the youth's criminal or antisocial behaviour.

Social-ecological theory helps explain the causal mechanisms that support and maintain juvenile crime and antisocial behaviour in youth. We know experientially, that young offenders commit crimes often in associations with peers, out of anger, due to lack of financial resources, due to poor impulse control, on a dare, because of an inability to delay gratification, or due to social pressures from delinquent peer groups. (In a small group of these youth, there are also factors of serious mental illness or impairment.) We know that some of these youth have grown up in impoverished and/or abusive homes, with antisocial role models who actively support aggression and deviance. We know that some of these youth grew up within homes with domestic violence

DYNAMIC SYSTEMIC MODEL

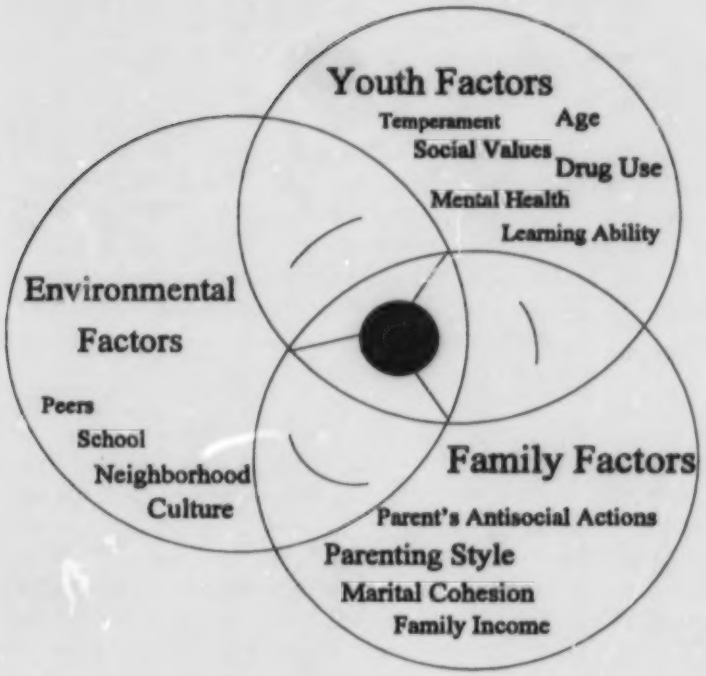

Figure 6.1: Integrated Causal Model of Antisocial / Conduct Problems in Youth

where they learned that aggression was an acceptable means of releasing frustration and anger. We know that there are increased levels of violence and criminal activities, in school settings within lower-income neighbourhoods. Thus we can conclude that the environment impacts upon the youth and the family in dynamic mutually inter-dependent ways, just as the youth impacts on the family. The family and the youth relate to each other in the context of their community setting and the larger social ecology in which they exist.

The proposed assessment and treatment service for antisocial and conduct disordered youth which is described in the following section attempts to address the complex nature of disruptive behaviour. The proposed service is based on a few basic tenants which are consistent across theoretical models, empirical evidence and practical experience.. These are:

1) Assessment and treatment of anti-social and conduct disordered adolescents is best conducted within the family and community systems in which such behaviour derived.

2) Connecting disconnected youth cannot be accomplished with punishment models for antisocial behaviour.

3) The complex nature of anti-social behaviour in youth demands an intervention approach which recognizes the impact of not only characteristics inherent to the youth, but the family, community and larger societal systems.

SECTION 7: PROPOSED INTEGRATED ASSESSMENT AND TREATMENT SERVICE

Overview

The proposed Program model attempts to integrate a service delivery structure that emphasizes the need for a collaborative multi-agency approach to youth at risk, with the needs as identified by provincial stakeholders and best practice approaches as identified in the literature. As such, the proposed Program model has several components. While the recommendation is for the implementation of all components, in order to provide an appropriate range of services, each of the components could also be implemented independently of the others.

Two major structural and systemic changes are being proposed to enhance service delivery to antisocial and conduct disordered youth in Nova Scotia. The first is a "Central Facility" that operates out of the Metro area and the second is a number of "Regional Teams" that will operate across the province as regional experts in the area of conduct disorder. As discussed in Section 3: Canadian Initiatives, both centralized and regionalized operations appear to make the best fit for a province with urban and rural communities and a small population base.

The Central Facility that is being proposed would operate a provincial inpatient assessment unit and provide consultation to Regional staff, co-ordination of province wide services, training and education of staff, promote and develop prevention and early intervention programs, and oversee program evaluation. As well, staff in the Central Facility would provide local assessment and treatment services to the Metro catchment area (see Figure 7.1).

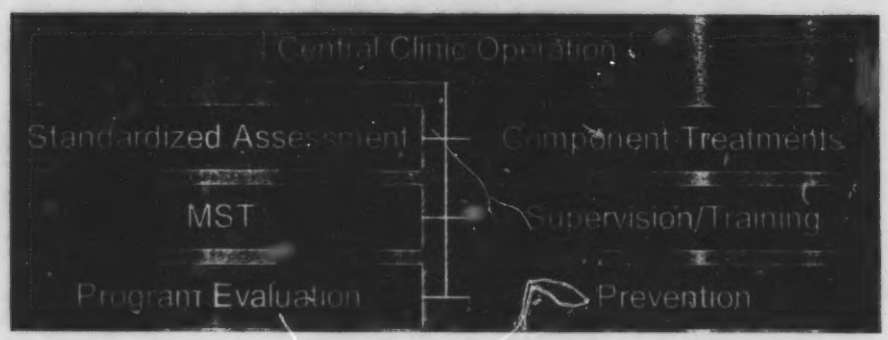

Figure 7.1 Central Facility Operations

Across the province, eleven Regional Teams are being proposed that would be composed of direct service staff from Mental Health, Community Services, Education and Justice. Following the New Brunswick model, these teams would be given the mandate of becoming local experts in the area of conduct disorder and would provide consultation and review with regard to at-risk youth in their area. Referrals to the Provincial Assessment Unit would come from these Regional Teams. The Regional Teams should be viewed as "Consultants" to service providers in the community. They are not expected to adopt cases referred to their Team, only to provide direction and make referrals to a number of other services or recommend a treatment plan. In addition to the local Regional Teams, staff affiliated with the Central Facility would be working in the local areas and would provide assessment and treatment services on a local basis. It is expected that this service would require one full time staff person in mental health to manage these duties. Unlike the Regional Teams, this staff person would work for the central facility and would take direction and assume the responsibilities similar to the staff working in the Central facility (see Figure 7.2).

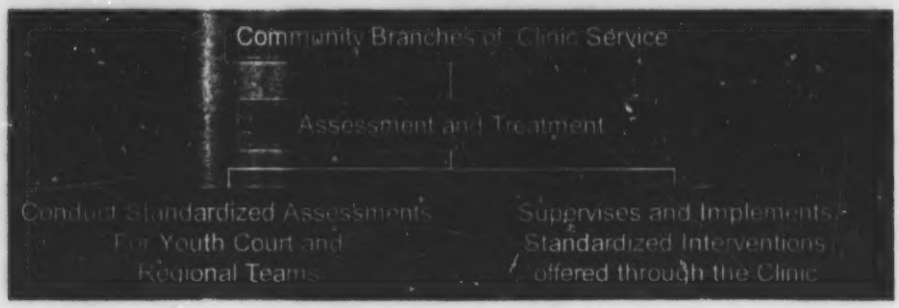
Community Branches of Clinic Service
Assessment and Treatment
Conduct Standardized Assessments For Youth Court and Regional Teams
Supervises and Implements Standardized Interventions offered through the Clinic

Figure 7.2: Outreach Programs of the Central Facility

The final part of the proposal is to pilot the Multisystemic Therapy (MST) Program in three regions. In order to meet the demand for rigorous treatment adherence, a formal association with either the developers of this program in the United States, or with the London Family Court Clinic, in Ontario, would be necessary.

The recommended Integrated Assessment and Treatment Service is composed of central and outreach services that complement each other. Referrals into the Service can come from one of two sources, either from the court system, or from the Regional Teams. Regional Teams will accept referrals from anyone in their jurisdiction who feels that a youth is at risk for serious conduct problems, including referrals for aftercare programs for youth discharged from Shelburne and Waterville Youth facilities. The Central Facility will support the Regional Teams in completing their mandate through support, recommendations, and service provision.

Regional Teams

The backbone of the proposed Integrated Assessment and Treatment Service is the development of Regional Teams. This vision of a decentralized model of operation is to give ownership of the assessment and treatment of at-risk youth to local communities. The need for community based, collaborative efforts in addressing the needs of this population was voiced strongly by individuals completing surveys and interviews and is supported by research. Regional Teams would be expected to develop general and local expertise in the area of conduct disorder and antisocial behaviour in youth. The Regional Teams would become adept at understanding the needs of these youth, identifying the services within their communities to meet these needs, and developing specific recommendations for youth referred for review.

It is recommended that these Regional Teams be developed in each of the eight Health Authorities outside the Metro area, with three teams operating withing the boundaries of Halifax County (Dartmouth/Eastern Shore, Halifax/Halifax County South and Sackville/Halifax County North). Each of the Regional Teams would have four members representing local service delivery within Mental Health, Community Services, Justice and Education. It is envisioned that the team members would meet on a bi-weekly basis for one-half day. This would require the support of the local agencies with which they are employed to allow this use of their time. However, the return to the local agencies would be seen in the systemic processing of referrals on conduct disordered youth, and the ability of local communities to access treatment and assessment services not previously accessible. It is envisioned that the Regional Team members will be provided with training at the time they are selected for the team. Ongoing support in the form of consultation and training will be provided by the Central Facility.

Referrals to the Regional Teams could be made by any workers within the constituent Departments or Agencies. The worker who was managing an at-risk youth, would be expected to provide a case presentation, outlining needs and interventions which have been attempted. The Regional Teams would then have four options. It is expected that in most cases, the Regional Teams would assist in developing a co-ordination of services for the youth and family utilizing local resources. The ability of the Regional Teams to galvanize a collaborative and integrated approach is seen as their primary strength. A second option is to refer to the Service to the outreach clinician who works in the local area. This referral may be for more thorough assessment of a young person or for specialized clinic programs. The Regional Teams can also make a referral to the Central Facility for an intensive inpatient assessment, or, in a case where a youth has previously been assessed in the inpatient unit and is in danger of losing a placement, the youth can be placed in the Assessment Unit for respite. The Regional Teams are the gatekeepers to the Inpatient Assessment Unit, with referrals to this Unit accepted *only* from Regional Teams. Finally, in regions where pilot programs are initiated, the Regional Team may make a referral to the MST Program. Regional Teams are consultants only. They are not to provide any direct service. However, it is expected that they will provide follow-up consultation with regard to youth referred to the Team. See Figure 7.3 for the options available to the Regional Teams.

Figure 7.3: Options available to the Regional Teams

Court Ordered Assessments

The Integrated Assessment and Treatment Service will accept court ordered assessments on young offenders for Disposition, Criminal Responsibility, Fitness to Stand Trial and Transfer to Adult Court. A Standard Protocol for these assessments will be established by the Central Facility and will include assessment in the following areas, as outlined in Section 5 of this report :

1. Family Functioning
2. Cognitive and Educational Functioning
3. Substance Abuse
4. Interpersonal/Social Functioning
5. Emotional and Behavioural Problems
6. Antisocial Attitudes and Beliefs
7. Personality and Mental Health Concerns
8. Community/Neighborhood Factors
9. Risks, Needs and Strengths

It is understood that when the court has asked for an assessment of a fairly narrow domain, such as Fitness or Criminal Responsibility, that not all of these areas will be addressed. If the court is requesting an assessment for Disposition, multiple domains of the youth's functioning need to be addressed, as well as the protective factors in the youth's environment that may be engaged in intervention. Interventions need to be tailored to the youth's needs, and in order to accomplish this, the assessment needs to evaluate the youth in all domains that can impact on antisocial behaviour.

In the Metro area, Central Facility Staff will complete court ordered assessments. Within the established regions, the outreach staff (see below) will complete most court ordered assessments on a local, outpatient basis, thus reducing the need for remand to institutions for such assessments, and the need for use of private practitioners or travel to the Metro area in order for such completion of such assessments. Completion of these assessments on a local level will require new staffing, tentatively labeled outreach staff, as it is recommended that these staff that are hired for the purpose of completing these assessments be employed and trained through the Central Facility in order to maintain a consistent provincial standard for assessment. It is expected that these staff will also become involved in the delivery of regional treatment services, as described below.

Intensive Inpatient Assessment Unit

A primary component of the Central Facility will be the Intensive Inpatient Assessment Unit. This is envisioned as a small unit (no more than six beds) which will provide an intensive four week assessment on youth, aged 12-18, referred through the Regional Teams. An important aspect of this Unit is the admission process. No youth referred through the Regional Team will be denied admission as long as a bed is available. It will be up to the Regional Teams to prioritize referrals with this admission policy in mind.

The four week assessment process will follow the models found in British Columbia and New Brunswick. During the first three weeks, intensive assessment with the youth, family, education system and other professionals involved with the youth will be completed. This assessment will be an expansion of that which is completed on an outpatient basis, with the components described above addressed in a comprehensive fashion. At the end of the third week, a preliminary report will be provided to the Regional Team, allowing for collaboration with the Regional Team around recommendations. Prior to discharge, a case conference will be held, with the youth, family and all parties involved with the family urged to attend. Through this process will evolve the development of an integrated case plan which will be brought back to the local community for implementation.

For youth who have been assessed through the Unit, respite placement will also be available. Such a placement will be for a maximum of two weeks. This is not intended to be a crisis admission. Rather, respite placement is intended for youth who are viewed as at risk of losing an established placement.

Clinical services to this Unit will be provided by staff assigned to the Central Facility. For the purpose of this unit, staff will consist of a full-time psychologist, a full-time social worker, a part-time psychiatrist and a part-time educational consultant. A number of possibilities have been identified with regard to the residential components (i.e., youth care aspects) of the Unit. A stand alone Unit could be developed, an existing facility could be approached to provide beds or the residential component could be contracted out.

Treatment Services

Treatment services will be offered on an outpatient basis and will be regionally based. Services will be limited to those interventions which have been shown to have some efficacy with conduct disordered and/or antisocial youth. These types of interventions have been described in Section 6 of the report and include:

1. Cognitive Behavioural Skills Training
2. Parent Management Training
3. Functional Family Therapy

It will be the responsibility of the clinicians working in the Central Facility to provide supervision and training to outreach clinicians. The Central Facility clinicians will also have the mandate of continuously seeking additional treatment interventions which have demonstrated promise in working with this population of youth.

Within the Regions, clinicians providing assessment will also implement treatment services. Integrating these clinicians within the local mental health services, while maintaining their mandate to provide services to this specific population is recommended.

Multisystemic Therapy (MST)

The MST program has been described in Section 6 in general principles. Training will be required prior to implementation of this program. MST must be considered the best researched intensive treatment model for severely conduct disordered youth and has demonstrated efficacy in a variety of settings. Implementing an MST program in Nova Scotia would be a significant commitment of financial and clinical resources. As well, as MST is described as having a lengthy learning curve, a commitment to a pilot program of several years is required. However, within the mandate of developing a best practice model, a pilot MST program is recommended.

It is recommended that an MST program be implemented in three sites, one within the Metro region, one in Cape Breton and one in the South Shore region. Other regions in the province would, initially, be used for comparison purposes. Expansion into other regions would be dependant upon a cost-benefit analysis of operating the MST program. An MST supervisor would be located in the Central Facility and supervise MST therapists in each cite. All staff involved in the MST program would require extensive training through an approved MST site (either in the United States or Ontario).

Referrals to the MST program would come from two sources. The Regional Teams in the areas where MST programs were operating could refer, as could the Integrated Assessment and

Treatment Service clinician working within the region. Ultimate determination with regard to the appropriateness of a referral would be the responsibility of the MST supervisor.

Additional Central Facility Services

In addition to the providing Intensive Inpatient Assessment, Court Ordered Assessments, Treatment Services for the Central Region and MST services, the Integrated Assessment and Treatment Service Central Facility would provide administrative support and co-ordination of services and would undertake a number of provincial responsibilities. These would include Training and Supervision, Program Evaluation and Research and development of Prevention Initiatives.

Training and Supervision. Standards for assessment and intervention would be determined at the Central Facility, where staff would be trained to meet these standards. Regular supervision would ensure that all staff are maintaining appropriate standards. As new assessment protocols and promising treatment initiatives are developed, clinicians will receive training to enable them to implement these new strategies within their local communities. As mentioned above, supervision of MST therapists would also occur within the Central Facility. Training and supervision opportunities will also be offered to students attending post-graduate programs in psychology, psychiatry and social work.

Program Evaluation and Research. It is recommended that a Program Evaluation component to the Integrated Assessment and Treatment Service be developed at the time of implementation of the Service. Program Evaluation should contain several components. These include:

Consumer Satisfaction: Input from professionals and families utilizing the Services programs will be sought in a formal manner. This will allow for evaluation and modification of services in terms of how well they provide for community needs.

Pre and Post Evaluation: For all intervention services, youth and family will be asked to completed standardized instruments prior to the initiation of treatment and upon completion. This will provide an evaluation of immediate treatment effect.

Collection of Baseline Data and Follow Up: For youths and families participating in Service programs, baseline data with regard to the youth's functioning within the family, school and community will be collected at the time of assessment. With permission of the youth and family, follow up data will be collected at six months, one year and two years following the youth and family involvement. In addition to the standardized instruments utilized in pre and post evaluations, markers of general functioning, such as school attendance, suspensions and involvement with the police will be collected.

It will be the responsibility of Central Facility staff to implement and maintain an evaluation of the Service and to make results of these evaluations available in a public format. It is hoped that Central Facility staff will be able to establish relationships with University based professionals for the purpose of collaboration on research efforts.

Promoting and Developing Prevention Program. A consistent theme in the collection of information from individuals working with this population, which is also supported by reviews of the literature, is the need for the development of preventative efforts. Life-course persistent offenders are those who demonstrated aggressiveness and other symptoms of conduct disorder prior to the age of ten. There are prevention programs in Nova Scotia, such as the BEST program, which report positive effects. Other programs in the United States and Canada also appear to show promise in preventing the development of anti-social behaviour. While the mandate of the present proposal was to identify a model for assessment and treatment, the importance of prevention must be acknowledged. Ideally, central to any assessment and treatment service for this population would be well developed prevention and early intervention programs. It is recommended that a mandate for identification and implementation of such programs be included as part of the Integrated Assessment and Treatment Service.

Staffing Requirements for the Proposed Service

Clearly this proposed service will require additional staffing in mental health services as it is recommending intensive assessment and intervention programs. It is expected that each of the 8 regional communities be provided with a Psychologist to do this work, and that this Psychologist will work for the Facility, be accountable to the Facility and be supported and trained by the Facility. It is also expected that these Psychologists become trained in standardized empirically based treatment programs such that they can implement, and eventually train and supervise others in the implementation of these services. In the areas where MST is being piloted, the clinicians would be required to participate in this training program as well. The Central Facility will require a full time staff complement for the Intensive Inpatient Assessment Unit as described previously. In addition, two full time Psychologists and a Social Worker would be required to complete the court ordered assessments and outpatient interventions offered at the facility. A center manager will be required, one that will oversee program implementation standards, quality assurance, research, and prevention measures. MST workers would need to be hired and trained. Bachelor level trained paraprofessionals have been shown to be able to implement MST under the guidance of trained experts.

Clinical staffing needs can be summarized as follows:

1) Central Facility Staff - 2 psychologists; 1 clinical social worker; 1 center manager (4 FTE)

2) Regional Outreach Staff - 1 psychologist per region to complete court ordered assessments and implement treatment servers (8 FTE)

3) Inpatient Clinical Staff - 1 psychologist, 1 clini cal social worker, .5 psychiatrist, .5 educational consultant (3 FTE)

4) MST Pilot - 1 supervisor, 6 MST workers (7 FTE)

In addition, there would be the need for an administ rative support staff (1.5 FTE) for the Central Service. Regional staff would be provided with administrative support through their local mental health services.

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Appendices available upon request from the authors of the report.

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Survey of Services Available in Nova Scotia for Youth Involved with Criminal Justice

What is your name? _____

What is your job title/position? _____

What is the name of your service program or agency? _____

Where are you located (e.g., site)? _____

Below you will find a series of questions about the services provided by you and your agency to youths between the ages of 12 and 18. Please answer each question by ticking the box next to the response that best corresponds to your experience or opinion.

1. What percentage of 12-18 year old clients served by your agency/program **have been involved with** the criminal justice system?

- ☐ Less than 5 %
- ☐ Between 5 and 10 %
- ☐ Between 11 and 25 %
- ☐ Between 26 and 50 %
- ☐ Between 51 and 99%
- ☐ 100 %

2 What percentage of the 12-18 year old clients that you service are **at risk of becoming involved with** the youth justice system because of antisocial acts (i.e., acts that would be cause for arrest if law enforcement were involved in the case)?

- ☐ Less than 5 %
- ☐ Between 5 and 10 %
- ☐ Between 10 and 25 %
- ☐ Between 25 and 50 %
- ☐ Between 51 and 99%
- ☐ 100 %

3. Does your program, service, or agency have a specific policy for dealing with youth who are involved with the young offender system?

☐ Yes ☐ No

4. Please check the **three most common** types of mental health problems that you see among this group of antisocial youth between the ages of 12 and 18.

- ☐ Anxiety
- ☐ Depression
- ☐ Substance Abuse
- ☐ Poor social skills or interpersonal problems
- ☐ Anger management problems
- ☐ Family dysfunction
- ☐ Antisocial values / behaviour
- ☐ Abuse (physical/sexual/emotional abuse or neglect)
- ☐ Attachment problems
- ☐ Inappropriate/deviant sexual behaviour
- ☐ Limited/lack of empathy
- ☐ Other (please specify):_____

_____

_____

4.1 Please indicate what you believe to be the **three most salient** environmental factors that are contributing to sustained antisocial behaviour of youth in this age group.

- ☐ Underachievement in school
- ☐ Poverty
- ☐ Lack of parental supervision
- ☐ Antisocial peer associations
- ☐ Antisocial role models in the family
- ☐ Lack of employment
- ☐ Lack of structure of free time
- ☐ Other _____

_____

5. What types of assessment services do you or your agency/program provide for at-risk or antisocial youth?

- ☐ No assessment services provided
- ☐ Informal assessments with no specific protocol
- ☐ Standard assessments for treatment purposes
- ☐ General psychiatric assessments
- ☐ General psychological assessments
- ☐ Specialized forensic risk/needs assessments
- ☐ Other (please specify): _____

_____

_____

5.1 Do you refer for assessment services elsewhere? ☐ Yes ☐ No

If yes, please describe below where you refer, for what type of assessment, and any obstacles that you have faced in obtaining assessments for this population of youth.

_____
_____
_____
_____
_____
_____

6. What types of services does **your agency** provide to adolescents (12 to18) who have committed offenses or are at high-risk of committing offenses due to their behavioural patterns?

- ☐ Outpatient or individual office visits with client and/or parent
- ☐ Group Treatments (e.g., Anger Management or Social Skills)
- ☐ In-home services (i.e., working with parents and youth in their own home)
- ☐ Psychiatric follow-up and monitoring
- ☐ Day-Hospital or Day Treatment Programs
- ☐ Inpatient or residential services
- ☐ Educational intervention or vocational programs
- ☐ School Consultation / Liaison
- ☐ Supervision of youth
- ☐ Arranging placements outside of the home
- ☐ Other (please specify): _____

6.1 Does **your agency** provide any **specialized** programs or services to deal with conduct-disordered or antisocial youth, or youth involved in the young offender system?

☐ Yes ☐ No

If yes, please describe below the specialized program and include any handout or brochure materials that you may have on these services.

_____
_____
_____
_____
_____
_____
_____

6.1. Are you aware of any specialized programs or services for conduct-disordered, antisocial or delinquent youth operating at **other agencies/services** in the province?

☐ Yes ☐ No

If yes, please describe the program(s) below

_____

_____

_____

_____

_____

_____

_____

_____

_____

6.2. Are you able to access these specialized programs/services for your clients that are offered at other agencies in the province?

☐ Yes ☐ No

7. What approaches to treatment or intervention do **you** use with youths who have antisocial problems or are involved in the justice system? Please check all that apply and then rank the top **three** interventions that you most prefer ("1" = top choice).

		Ranked Preference
☐	Behavioural management in the home and/or school	___
☐	Social skills training	___
☐	Anger management training	___
☐	Parent Training / Education / Support	___
☐	Supportive counseling for adolescents	___
☐	Cognitive-behavioural methods or strategies	___
☐	Family counseling/therapy	___
☐	Insight-oriented psychodynamic psychotherapy	___
☐	Substance Abuse Counseling/treatment	___
☐	Restitution	___
☐	Apology letters	___
☐	Increased level of supervision or imposition of more strict probation conditions	___
☐	School suspensions or detentions	___
☐	School conferences with parents	___
☐	Student Services in the school setting (i.e., Social Work or Psychology)	___
☐	Referral to special classroom environment	___
☐	Assist youth in obtaining employment/Vocational counseling	___
☐	Engagement of Youth Support Workers	___
☐	Other interventions 1). _____	___
	2). _____	___
	3). _____	___

7.1 How successful do you find the top three interventions, as ranked above, in reducing the recidivism of criminal behaviour or aggressive / violent / antisocial behaviour in this population of youths?

Type of Intervention	*How successful is this intervention in addressing recidivism?*
1. _____	_____Somewhat _____Moderately _____Highly Successful
2. _____	_____Somewhat _____Moderately _____Highly Successful
3. _____	_____Somewhat _____Moderately _____Highly Successful

7.2 Do the services you provide to this group of youths have any standardized outcome evaluation processes associated with them (e.g., pre/post evaluation measures) to assist you in determining the effectiveness of the intervention(s)?

☐ Yes ☐ No

If yes, please briefly describe your outcome evaluation procedures below.

_____
_____
_____
_____
_____
_____
_____
_____

8. How long is the waiting period for youth with conduct or antisocial problems to obtain services from **your agency**?

- ☐ no waiting period (less than a week)
- ☐ 1 to 2 weeks
- ☐ 3 to 4 weeks
- ☐ 1 to 2 months
- ☐ 3 to 4 months
- ☐ 6 months or more

9. Does your agency/service **refer** to other individuals or agencies in order to obtain intervention or treatment for this population of youths?

☐ Yes ☐ No

If yes, please identify the type of individuals or agencies you refer to below...

- ☐ Outpatient mental health clinics
- ☐ Private practicing psychologists or social workers
- ☐ Private therapists not associated with a professional discipline
- ☐ In-home Family Support / Home Run / Youth Workers
- ☐ Inpatient or residential agencies
- ☐ Substance abuse assessment/treatment services
- ☐ Educational/vocational assessment/intervention services
- ☐ Law enforcement programs
- ☐ Other (please specify):

_____

_____

_____

9.1 Are the waiting lists of other agencies/services often an obstacle to your youth clients receiving services?

☐ Yes ☐ No

If yes, please explain below.

_____

_____

_____

_____

10. Do you or your agency/service have a protocol regarding the coordination of service delivery for this population of youths?

☐ Yes ☐ No

If yes, do you have relationships with other professions or agencies (e.g., law enforcement, mental health, probation, schools, social service agencies) that assist you in treating or responding to the needs of this population? Do you view this as a requirement of a good service delivery model for this population?

_____

_____

_____

_____

_____

_____

_____

_____

11. Do you feel there should be more specialized programs to deal with this population of young people than is currently available?

- ☐ Yes - there is a service gap for this sub-group of youths
- ☐ No - appropriate services are currently being provided to these youths

If yes, please describe below the types of programs/services you envision for this population to ideally address their service needs...

Thank you for taking the time to complete this survey. This information you have provided us with is very valuable and will assist us in developing a "best-service" approach to the assessment and treatment of at-risk and antisocial youth.

APPENDIX B

Survey of Services Available in Nova Scotia for Youth Involved with Criminal Justice

Name _____

Title/position (please check one)

- ☐ Legal Aid / Defense Attorney
- ☐ Crown Attorney
- ☐ Honourable Judge of Family / Supreme / Provincial Court of Nova Scotia

Site: _____

Below you will find a series of questions regarding assessment and intervention services provided to youth between the ages of 12 and 18 who have been or are at risk of becoming involved in the youth justice system. Please answer each question by ticking the box next to the response that best corresponds to your experience or opinion. These questions refer to the mental health or service needs of this population and your answers should be based upon your experience or opinion. Please feel free to add any comments to your responses.

1. Please check the **three most common** types of mental health problems that you see among this group of antisocial youth between the ages of 12 and 18.

   - ☐ Anxiety / Depression
   - ☐ Substance Abuse
   - ☐ Poor social skills or interpersonal problems
   - ☐ Anger management problems
   - ☐ Family dysfunction
   - ☐ Antisocial values / behaviour
   - ☐ Victim of Abuse (physical/sexual/emotional abuse or neglect)
   - ☐ Attachment problems
   - ☐ Inappropriate/deviant sexual behaviour
   - ☐ Limited/lack of empathy
   - ☐ Other (please specify):_____
     _____
     _____
     _____

2. Please indicate what you believe to be the **three most salient** environmental factors that are contributing to sustained antisocial behaviour of youth in this age group.

- ☐ Underachievement in school
- ☐ Poverty
- ☐ Lack of parental supervision
- ☐ Antisocial peer associations
- ☐ Antisocial role models in the family
- ☐ Lack of employment
- ☐ Lack of structure of free time
- ☐ Other _____

_____

_____

_____

3. What types of assessment services do you request for at-risk or antisocial youth?

- ☐ No assessment services requested
- ☐ Informal assessments with no specific protocol
- ☐ Assessment for Disposition
- ☐ Assessments for Transfer to Adult Court
- ☐ Assessments for Competency to Stand Trial
- ☐ General psychiatric assessments
- ☐ General psychological assessments
- ☐ Specialized forensic risk/needs assessments
- ☐ Other (please specify): _____

_____

_____

3.1 Where do you refer for assessments? Please describe below where you refer, for what type of assessment, and any obstacles that you have faced in obtaining assessments for this population of youth.

_____

_____

_____

_____

_____

_____

_____

_____

4. What types of service do you foresee being most helpful to reduce recidivism for adolescents (12 to18) who have committed offenses?

- ☐ Outpatient mental health clinics
- ☐ Day-Hospital or Day Treatment Programs
- ☐ Psychiatric follow-up and monitoring
- ☐ Private practicing psychologists or social workers
- ☐ In-home Family Support / Home Run / Youth Workers
- ☐ Inpatient or residential agencies
- ☐ Substance abuse assessment/treatment services
- ☐ Educational/vocational assessment/intervention services
- ☐ Law enforcement programs in community
- ☐ Supervision of youth by probation
- ☐ School Consultation / Liaison
- ☐ Arranging placements outside of the home
- ☐ Other (please specify):

_____
_____
_____

4.1 Are the waiting lists or demands for a particular service often an obstacle to these youth receiving services?

☐ Yes ☐ No

If yes, please explain below.

_____
_____
_____
_____
_____
_____
_____
_____

4.2 Are there any specialized programs or services to deal with conduct-disordered or antisocial youth, or youth involved in the young offender system that you are aware of (outside of the youth detention centers) ?

☐ Yes ☐ No

If yes, please describe below. _____

_____

_____

_____

_____

5. In your experience with these youth, what approaches to treatment or intervention do you see as most valuable for youths who have antisocial problems or are involved in the justice system? Please check all that apply and then rank the top three interventions that you feel are most effective with this population ("1" = top choice).

		Ranked Preference
☐	Behavioural management in the home and/or school	___
☐	Social skills training	___
☐	Anger management training	___
☐	Parent Training / Education / Support	___
☐	Supportive counseling / therapy for adolescents	___
☐	Family counseling/therapy	___
☐	Substance Abuse Counseling/treatment	___
☐	Restitution	___
☐	Incarceration	___
☐	Apology letters	___
☐	Increased level of supervision or imposition of more strict probation conditions	___
☐	School conferences with parents	___
☐	Student Services in the school setting (i.e., Social Work or Psychology)	___
☐	Assist youth in obtaining employment/Vocational counseling	___
☐	Engagement of Youth Support Workers	___
☐	Other interventions 1). _____	___
	2). _____	___
	3). _____	___

5.1 How successful do you think these top three interventions, as ranked above, would be in reducing the recidivism of criminal behaviour or aggressive / violent / antisocial behaviour in this population of youths? This is your opinion based upon your experience in dealing with these youth in a legal forum.

Type of Intervention		*How successful is this intervention in addressing recidivism?*
1.	_____	____Somewhat ____Moderately ____Highly Successful
2.	_____	____Somewhat ____Moderately ____Highly Successful
3.	_____	____Somewhat ____Moderately ____Highly Successful

5.2 Are you aware of any standardized outcome evaluation processes associated with interventions (e.g., pre/post evaluation measures) that would measure the effectiveness of the intervention(s)?

❑ Yes ❑ No

If yes, please briefly describe.

1. Do you think that a protocol regarding the coordination of service delivery for this population of youth is needed ?

❑ Yes ❑ No

What do you think is needed in this province to meet the needs of this population (i.e., who should be working together to provide a good service to these youth, Justice?, Mental Health?, Community Services?, Drug Dependency?, etc.)

7. Do you feel there should be more specialized programs to deal with this population of young people than is currently available?

- ☐ Yes - there is a service gap for this sub-group of youths
- ☐ No - appropriate services are currently being provided to these youths

If yes, please describe below the types of programs/services you envision for this population to ideally address their service needs...

Thank you for taking the time to complete this survey. This information you have provided us with is very valuable and will assist us in developing a "best-service" approach to the assessment and treatment of at-risk and antisocial youth.

APPENDIX C

Specific Groups Represented in Surveys and Interviews

1. **Youth Detention Centres**
   - Shelburne Youth Centre
   - Nova Scotia Youth Centre
   - Cape Breton Young Offender Detention Centre

2. **Justice Department – Probation Services**
   - Amherst Office
   - Antigonish office
   - Bedford Office
   - Bridgewater Office
   - Dartmouth Office
   - Glace Bay Office
   - Halifax Office
   - New Glasgow Office
   - North Sydney Office
   - Port Hawkesbury Office
   - Shelburne Office
   - Truro Office
   - Windsor Office
   - Yarmouth Office

3. **Youth Resource Centres & Youth Alternative Societies**
   - Salvation Army Cape Breton Intensive Support & Supervision Program
   - Cape Breton Youth Resource Centre - Sydney
   - Island Community Justice Society – Cape Breton Regional Municipality
   - Community Justice Resource Centre – East Hants & Colchester Counties
   - John Howard Society (Restorative Justice) – Pictou, Antigonish, Guysborough Counties
   - Cumberland Community Alternatives Society – Cumberland County
   - Alternative Programs for Youth & Families Inc. – Bridgewater
   - Youth Alternative Society – Halifax Regional Municipality
   - Southwest Community Justice Society – Digby, Yarmouth, & Shelburne

4. **Addiction Services/Drug Dependency**
   - Dartmouth
   - Halifax
   - Pictou
   - Sydney
   - *Crosbie Centre – Valley?*

5. **Family & Children's Services**
   - Annapolis County
   - Cumberland County
   - Hants County
   - King's County
   - Lunenburg County
   - Halifax Regional Municipality

   M'kmaq Family & Children's Services
   - Hants County

   Department of Community Services
   - Antigonish
   - Digby
   - Sackville

   Children's Aid Society
   - Cape Breton-Victoria Counties
   - Pictou County
   - Inverness-Richmond Counties

6. **Education**
   - Chignecto-Central Regional School Board
   - Halifax Regional School Board
   - Southwest Regional School Board
   - Strait Regional School Board
   - Cape Breton-Victoria Regional School Board
   - *Barrington (Shelburne County)*
   - *Digby (Digby County)*

7. **Mental Health**
   - Colchester Regional Hospital – Child, Adolescent, & Family Services
   - Highland View Regional Hospital – Child & Adolescent Program
   - St. Martha's Regional Hospital – Child & Adolescent Program
   - District Health Authority for Antigonish, Guysborough, Canso, & Sherbrooke
   - South Shore Regional Hospital – Child & Adolescent Team
   - Outpatient Mental Health – Bridgewater & Liverpool
   - NSHCC – Dartmouth
   - Digby Mental Health
   - IWK-Grace – Day Treatment Program
   - IWK-Grace- Children's Response Program
   - IWK-Grace – Inpatient Psychiatry Service
   - IWK-Grace – Community Mental Health
   - Northern Regional Child & Adolescent Psychiatric Services
   - Valley Regional Hospital – Child & Adolescent Service
   - Soldier's Memorial Hospital – Middleton Mental Health Centre
   - Aberdeen Hospital – Child & Adolescent Services
   - Yarmouth Regional Hospital – Child & Adolescent Program
   - Yarmouth Regional Health Centre – Mental Health Services
   - Cape Breton Regional Hospital – Child & Adolescent Mental Health

8. **Group Homes/Residential Centres**
   - Mullin's House – Northern Region
   - Dayspring Adolescent Treatment Centre – Western Region
   - Phoenix Youth Program – Central Region
   - Bridges Program – Northern Region
   - Reconnect Residential Services – Northern Region
   - Janus Program – Northern Region
   - King's Rehabilitation Centre – Western Region
   - Hebron Residential Centre – Western Region

9. **Policing Services**
   - RCMP Community Policing – Bridgewater

APPENDIX D

Youth Justice Feasibility Study

Survey Results

Respondent Representation

N = 126

• Correctional Services – Probation	20%
• Drug Dependency/Addiction Services	4%
• Department of Community Services/Children's Aid Society	13%
• Education	12%
• Mental Health	21%
• Youth Resource Centres/Youth Alternative Societies	7%
• Group Homes/Residential Centres	10%
• Youth Detention Centres	12%
• Police	0.7% (one individual)

N = 26

• Judges/Justices	31%
• Crown Attorneys	23%
• Legal-Aid/Defence Attorneys	38%
• Youth Court Support Workers	8%

NOTE: All numbers refer to the percentage of respondents endorsing the specified variable (N = 135)

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 16)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterna Societies (n = 10)
Percentage of youth cases involved in criminal justice system:								
Less than 5%	11	0	17	0	0	40	0	0
5-10%	11	0	28	0	0	33	7	0
11-25%	22	20	34	0	0	20	7	10
26-50%	39	40	7	7	0	7	57	0
51-99%	11	40	10	4	6	0	29	0
100%	6	0	3	89	94	0	0	90
Percentage of youth cases at risk of involvement in criminal justice system:								
Less than 5%	6	0	3	4	0	37	0	0
5-10%	6	0	0	0	0	19	0	0
11-25%	11	0	34	4	0	25	0	0
26-50%	[illegible]	20	28	4	0	12	14	11
51-99%	39	80	28	27	7	6	71	0
100%	6	0	7	61	93	0	14	89
Yes - we have a policy to deal with at risk antisocial youth	17	40	3	100	100	31	43	100
Yes - agency has a protocol for working with Antisocial youth	18	50	28	65	69	31	69	70
Yes - there is a gap in Service for antisocial youth	100	100	93	96	80	100	100	100

Assessment Services

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 16)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterna Societies (n = 10)
Common Presenting Mental Health Problems of Antisocial Youth:								
Anxiety	16	0	17	3	0	18	14	0
Depression	11	0	20	7	6	31	14	10
Substance Abuse	17	100	52	85	75	62	29	80
Social Skills Problems	72	20	59	33	56	31	64	50
Anger Problems	44	60	52	48	62	75	50	80
Family Dysfunction	67	80	69	74	50	81	71	80
Antisocial Attitudes	0	40	10	26	37	31	29	10
Abuse	44	0	14	11	19	6	29	0
Attachment Problems	44	0	38	4	0	0	57	0
Sexual Misbehavior	0	0	3	4	0	0	7	0
Lack of empathy	6	0	10	0	0	6	21	0
"Other" problem	0	0	21	7	0	12	0	0

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 16)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterns Societies (n = 10)
Most common Environmental Factors Related to Antisocial Youth:								
School Underachievement	44	20	59	59	50	56	36	40
Poverty	28	20	48	7	31	12	29	10
Poor Parental Supervision	67	80	55	74	56	75	71	90
Antisocial Peers	28	60	38	70	75	50	43	50
Antisocial Family Role Models	44	40	45	26	56	44	36	30
Unemployment	11	0	14	11	0	6	0	0
Lack of Structure in Leisure Time	39	40	31	33	43	50	71	70
"Other" Factor	22	40	21	11	0	12	0	10
Type of Assessment Services Provided:								
No service	11	0	0	15	0	12	36	30
Informal	61	0	14	30	31	44	36	40
Standard for treatment	17	80	83	27	94	12	36	20
Psychiatric	6	20	55	11	31	0	14	10
Psychological	17	20	41	7	56	31	21	30
Risk/need	0	20	17	50	37	0	0	0
"other"	28	60	14	37	25	31	7	30

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 16)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterna Societies (n = 10)
Yes - I refer for assessments elsewhere	100	80	57	96	75	93	86	60

Treatment Services

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 16)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterna Societies (n = 10)
Types of Services Provided by Agency:								
Outpatient individual	50	100	76	63	19	29	57	30
Group Treatment	50	100	55	37	94	36	64	70
In-Home Service	83	0	48	22	0	7	57	30
Psychiatric Follow-Up	6	0	72	15	19	0	14	0
Day Treatment	11	40	17	0	0	0	0	0
Inpatient or Residential	17	80	24	7	50	0	79	0
Educational or Vocational Interventions	28	80	14	15	0	43	57	30
School Consult or Liaison	61	100	76	74	75	71	50	40
Supervision of Youth	39	20	14	78	81	14	79	50

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 16)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterna Societies (n = 10)
Arrange Placement Outside Home	94	20	21	33	50	0	43	30
"other" service	11	40	10	22	37	19	7	60
Yes - we offer any specialized programs for antisocial youth	28	40	17	31	100	20	36	80
Yes - I'm aware of specialized services at <u>other</u> agencies	50	40	44	69	37	67	31	50
Yes - I'm able to access the specialized services of other agencies	40	33	25	80	45	45	33	33
Specific intervention techniques used by individual/agency:								
Behavioral Management	76	40	83	52	50	87	57	40
Social Skills Training	41	80	69	30	94	53	93	30
Anger Management	59	80	79	37	100	87	71	80
Parent Training, Education, or Support	82	80	83	22	37	27	50	20
Supportive Counseling for Youth	59	80	72	70	94	87	100	30
Cognitive Behavioral Strategies	25	100	79	33	87	47	43	10

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 16)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterns Societies (n = 10)
Family Counseling or Therapy	53	60	65	26	25	21	29	0
Insight-oriented Psychotherapy	6	20	17	7	12	7	0	0
Substance Abuse Counseling or Treatment	29	100	31	41	100	20	29	30
Restitution	6	0	17	63	56	27	21	80
Apology Letters	6	0	17	59	56	20	36	70
Increased Supervision	18	20	34	74	19	21	57	40
School Suspension or Detention	0	20	3	11	6	60	29	10
School Conferences with Parents	41	20	48	30	12	80	50	30
Student Services	18	0	24	26	12	67	7	0
Special Classroom	19	20	24	11	37	33	14	0
Assist with Employment or Vocational Counseling	41	60	31	52	50	43	57	30
Youth Workers	47	0	31	18	25	7	57	20
"Other" strategy	23	20	28	15	37	20	0	40

Based on rankings, the most preferred intervention strategies across agencies were:
Behavioral Management, Substance Abuse Intervention, Parent Training/Support/Education, Supportive Counseling for Youth, & Anger Management

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 16)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterna Societies (n = 10)
Yes - we have a standardized outcome evaluation process	7	60	14	30	71	7	42	30
Length of Waiting List at your agency:								
No waiting period	39	0	7	26	56	44	0	0
Depends on service or need	17	20	10	4	6	19	21	10
1 to 2 weeks	11	60	7	26	25	6	0	40
3 to 4 weeks	11	20	10	11	0	6	35	20
1 to 2 months	11	0	14	4	0	0	7	0
3 to 4 months	0	0	14	7	0	0	7	0
6 months or more	0	0	34	7	0	0	7	0
Yes - we refer to other agencies for intervention:	100	100	89	96	75	100	92	90
Outpatient Mental Health Clinic	83	80	21	89	50	100	92	50
Private psychologists or social workers	89	0	17	67	37	73	77	55
Private therapist (non-registered)	22	0	0	15	12	0	23	0
In home family support (Home Run or Youth Workers)	72	20	55	41	25	27	54	10

Variable	Community Services & CAS (n = 18)	Drug Dependency (n = 5)	Mental Health (n = 29)	Probation (n = 27)	Youth Detention Centres (n = 18)	Education (n = 16)	Group Homes/Residential Centres (n = 14)	Youth Resource/Alterna Societies (n = 10)
Inpatient or Residential	78	0	24	52	25	33	54	11
Substance Abuse Intervention	100	0	86	93	69	80	61	100
Educational or Vocational Interventions	72	60	41	74	56	33	54	33
Law Enforcement	39	20	24	48	12	53	69	22
"Other" referrals	17	20	21	30	6	13	8	33
Yes - The waiting lists of other agencies is an obstacle to my clients receiving treatment	83	80	62	77	67	100	93	77

Judge/Justice & Lawyer Respondent Results (N = 26)

Variable	Judge/Justice (n = 8)	Crown Attorney (n = 6)	Legal Aid/ Defence Attorney (n = 10)	Youth Court Support Worker (n = 2)
Yes - there is a gap in Service for antisocial youth	100	100	100	100

Assessment Services

Variable	Judge/Justice (n = 8)	Crown Attorney (n = 6)	Legal Aid/ Defence Attorney (n = 10)	Youth Court Support Worker (n = 2)
Common Presenting Mental Health Problems of Antisocial Youth:				
Anxiety/Depression	12	17	20	0
Substance Abuse	63	83	70	100
Social Skills Problems	25	33	40	50
Anger Problems	63	50	40	100
Family Dysfunction	63	83	100	50
Antisocial Attitudes	62	17	20	0
Abuse	12	0	10	0
Attachment Problems	25	0	0	0
Sexual Misbehavior	0	0	0	0
Lack of empathy	0	0	0	0
"Other" problem	0	33	10	0

Variable	Judge/Justice (n = 8)	Crown Attorney (n = 6)	Legal Aid/ Defence Attorney (n = 10)	Youth Court Support Worker (n = 2)
Most common Environmental Factors Related to Antisocial Youth:				
School Underachievement	62	0	40	0
Poverty	38	50	50	0
Poor Parental Supervision	75	67	60	50
Antisocial Peers	50	100	40	50
Antisocial Family Role Models	62	50	50	50
Unemployment	0	0	10	0
Lack of Structure in Leisure Time	25	33	30	100
"Other" Factor	0	17	20	0
Requested Assessment Services				
No service	0	0	10	0
Informal	0	0	0	0
For Disposition	100	67	60	100
Transfer to Adult Court	25	17	20	0
Competency	62	67	50	50
Psychiatric	62	83	40	0
Psychological	75	83	50	100
Risk/need	38	17	20	0
"other"	12	33	30	50

Treatment Services

Variable	Judge/Justice (n = 8)	Crown Attorney (n = 6)	Legal Aid/ Defence Attorney (n = 10)	Youth Court Support Worker (n = 2)
Types of Services Considered Helpful				
Outpatient Individual	50	83	40	50
Day Treatment	50	67	50	50
In-Home Service	88	100	80	100
Psychiatric Follow-Up	62	67	60	100
Private Practitioners	38	67	50	0
Inpatient or Residential	50	100	60	50
Substance Abuse Counseling	88	83	60	100
Educational or Vocational Interventions	50	50	30	100
Law Enforcement	25	50	10	0
School Consult or Liaison	38	50	20	50
Supervision of Youth	50	50	10	0
Arrange Placement Outside Home	62	83	20	0
"other" service	38	17	10	0
Yes – I'm aware of specialized programs or services for antisocial youth	71	67	30	0

Variable	Judge/Justice (n = 8)	Crown Attorney (n = 6)	Legal Aid/ Defence Attorney (n = 10)	Youth Court Support Worker (n = 2)
Specific intervention techniques Considered Helpful:				
Behavioral Management	50	100	70	100
Social Skills Training	50	83	60	50
Anger Management	100	100	50	100
Parent Training, Education, or Support	88	83	70	50
Supportive Counseling for Youth	75	83	70	100
Family Counseling or Therapy	75	100	80	50
Substance Abuse Counseling or Treatment	100	100	60	100
Restitution	25	50	10	50
Incarceration	38	67	10	0
Apology Letters	12	67	20	50
Increased Supervision	75	83	10	50
School Conferences with Parents	12	67	20	100
Student Services	50	100	40	50
Assist with Employment or Vocational Counseling	62	100	50	0
Youth Workers	75	100	40	100
"Other" strategy	12	33	20	50

Based on rankings, the most preferred intervention strategies across judges/justice/lawyers were:
Supportive counseling for youth, Substance Abuse Counseling, Parent training/Support/Education, Youth Support Worker, Behavioral Management, anger management, Family Counseling/therapy, & Social Skills Training

Variable	Judge/Justice (n = 8)	Crown Attorney (n = 6)	Legal Aid/ Defence Attorney (n = 10)	Youth Court Support Worker (n = 2)
Yes – I'm aware of standardized outcome evaluation for interventions	0	17	0	0
Yes – A protocol for working with other agencies is needed for good service delivery	,00	100	100	100

APPENDIX E

Interviews - Participating Agencies

- Shelburne Youth Centre
- Family and Children's Services - Yarmouth
- Hebron Residential Centre
- Probation Services - Yarmouth
- Mental Health-Yarmouth Regional Hospital
- Legal Aid - Kentville
- Nova Scotia Youth Centre
- Probation Services - Kentville
- Mental Health - Highland View Regional Hospital
- Cape Breton Victoria School Board
- Mental Health - Cape Breton Regional Hospital
- Probation Services - North Sydney
- Children's Aid Society of Cape Breton
- Probation Services - Port Hawkesbury
- Mental Health - St. Martha's Hospital
- Department of Community Services - Antigonish
- Antigonish School Board
- Community Justice Resource Centre - Truro
- Probation Services - Truro
- Mental Health - Colchester Regional Hospital
- Child and Family Services - Truro
- Mental Health-Aberdeen Hospital
- Day Treatment - IWK Health Centre
- Probation Services - Bedford

APPENDIX F

Interviewees - Canadian Initiatives

New Brunswick:

Bob Eckstein
Dr. Bill Morrison
Jacques Duclos
Gaeten Theriault

Ontario

Alison Cunningham
Alan Leschied

Saskatchewan

Bryan Rector
Brian Werry

Alberta

Colleen Shopland
Gerry Wright